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ABSTRACT

Underscoring the importance of active planning for constructive change in the nursing profession, the papers in these proceedings highlight the need for nursing to remain pro-active in the management of nursing education and patient care environments. The proceedings contain: (1) "Pro-Active Planning for Nursing at the Federal Level," by Jo Eleanor Elliott; (2) "Nursing and the State Legislature: A Critical Key to Our Future," by Judy DeMers; (3) "Pro-Activating a Collaborative Service Education Climate," by Joyce J. Fitzpatrick and Edward Halloran; (4) "From Tension to Teamwork: Promoting Positive Interprofessional Relationships," a panel discussion by Thomas Lant, Geraldine Price, Mary M. Janata, and Claire V. Wolfe; (5) "Resolve through Sharing: A Comprehensive Program for Grieving Families," by Sara Wheeler and Rana Limbo; (6) "Collaboration between Nursing Education and Service -- A Pro-Active Decision-Making Model," by Donna Deane and Sue Fitzsimons; (7) "Problem-Solving Management in a Pro-Active Environment: Developing Therapeutic Interventions for Children of Domestic Violence," by Deborah Wallace and Barbara O'Brien; (8) "An Assessment Process for Nursing Staff Patterns in Ambulatory Care," by Joann Genovich-Richards; (9) "Summer Nurse Extern Program," by Mary O'Leary and Beth Bongard; (10) "A Service/Education Relationship Model," by Jamie M. Blair; (11) "Descriptors for Nursing Care Provided under DRG's (Diagnosis Related Groups)" by Lynne Cheatwood and Patricia Martin; and (12) "Model Senior Wellness Centers: Self-Responsibility," by Laura Schubert. (AYC)

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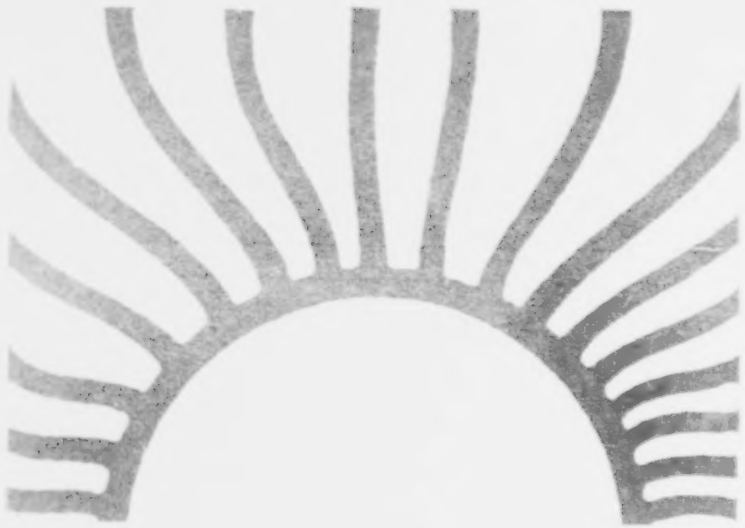
Thriving or Surviving?

Managing Pro-Active Environments for Nursing



Midwest Alliance in Nursing Fall Workshop

September 7-8, 1984

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THRIVING OR SURVIVING?
MANAGING PRO-ACTIVE ENVIRONMENTS FOR NURSING

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THRIVING OR SURVIVING
MANAGING PRO-ACTIVE ENVIRONMENTS FOR NURSING

PREFACE

As the economic and political changes were rapidly taking effect upon Midwest nursing in late 1984, MAIN's Fall Workshop focused on the need for nursing to remain pro-active (as opposed to re-active) in the management of nursing education and patient care environments. "Pro-active" means actively planning for constructive change rather than waiting for change to fall upon the profession and scrambling to adapt to conditions without forethought.

The program speakers shared ideas and strategies for turning critical challenges into positive outcomes for health care. They provided examples of nursing management that encouraged nurses' involvement in decision-making and showed how this, in turn, can bring improvements in patient care.

Especially significant were updates on the federal-level nursing activities by Jo Eleanor Elliott. Members of Ohio's Joint Committee on Interprofessional Relations of the Ohio Medical Society and Ohio Nurses' Association shared their model for fostering cooperative relationships among health care professionals--a particular goal of MAIN.

Judy DeMers, nurse, Associate Dean, and State Representative for District 17-18 in North Dakota showed the importance and effectiveness of pro-active efforts at the state legislative level. A dual presentation by Dean Joyce Fitzpatrick of Case Western Reserve University and Edward Halloran, Senior Vice President and Director of Nursing University Hospitals of Cleveland described methods for establishing a collaborative service-education climate.

The outcome of the shared presentations was to offer new hope for attendees to 'thrive' rather than simply to 'survive' in the face of economic and professional pressures.

The Editors

ACKNOWLEDGEMENTS

Our special thanks are extended to the MAIN Member Agencies for their support and participation in MAIN's semi-annual programs. The editors also express their appreciation to the Program Committee and Governing Board for their support, guidance and direction as well as the speakers who contributed their time, talent, and unique perspective of pro-active nursing environments.

We are also grateful to MAIN's Administrative Secretary, Vicki Johnson, who prepared all manuscripts for these Proceedings. Finally, the funding support from the W. K. Kellogg Foundation, which has assisted MAIN in organizing and presenting regional programs of quality, is also gratefully acknowledged.

The Editors.

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JO ELEANOR ELLIOTT, RN, AM, FAAN, Director, Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration, Public Health Service, Department of Health and Human Services. With 34 years experience in professional nursing, Ms. Elliott's roles have focused on planning and policy development, human resource management, teaching, consulting and research. In addition to her position as director, she also serves as chairman of the National Advisory Council on Nurse Training. Previously, she held the position of Chief Executive Officer of the Western Council on Higher Education for Nursing and the Director of Nursing Programs for the Western Interstate Commission on Higher Education. A graduate of the University of Michigan, she received her Masters of Arts in Nursing Education from the University of Chicago. She holds honorary degrees from St. Anselm's College, Boston University and the University of Colorado and Eastern Kentucky University. A member of Sigma Theta Tau, Ms. Elliott is also a fellow of the American Academy of Nursing and a recipient of the National League for Nursing's Mary Adelaide Nutting Award.

JUDY LEE DeMERS, RN, MEd, Associate Dean for Student Affairs and Admissions, University of North Dakota, School of Medicine and Associate Director of the Office of Rural Health in Grand Forks, North Dakota. A former public health nurse, she turned public servant in 1982 following her election as State Representative for District 17-18 of the North Dakota House Representatives. Active in politics, Ms. DeMers is a member of the Committee on State and Federal Government and the Committee on Social Services and Veteran's Affairs for the State of North Dakota. A graduate of the University of North Dakota and the University of Washington, she is presently working toward her doctorate at the University of Washington.

JOYCE JEAN FITZPATRICK, RN, PhD, FAAN, Dean and Professor, Frances Payne Bolton School of Nursing, Case Western Reserve University and Administrative Associate, University Hospitals of Cleveland, Ohio. Dr. Fitzpatrick received her bachelor's degree in nursing from Georgetown University, Washington, D.C. and her master's degree in Psychiatric and Mental Health Nursing from Ohio State University, Columbus, Ohio. She earned her doctorate in nursing from New York University, New York. One of the organizers for Midwest Nursing Research Society, she also served as the organization's first president. Dr. Fitzpatrick was the recent recipient of MNRS's Award for Distinguished Contributions to Nursing Research in the Midwest.

EDWARD J. HALLORAN, RN, PhD, Senior Vice President, Director of Nursing, University Hospitals of Cleveland, and Associate Professor, Frances Payne Bolton School of Nursing, Case Western Reserve University. Dr. Halloran obtained his diploma from New Britain General Hospital School of Nursing, New Britain, Connecticut; and a baccalaureate degree from Southern Connecticut State College, New Haven, Connecticut. He completed

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GERALDINE PRICE, RN, MSN, Chief, Division of Nursing, Ohio Department of Health, Columbus, Ohio. Active in the support of nurse-physician teamwork, Mrs. Price serves as co-chairman of the Ohio State Medical Association-Ohio Nurses' Association Liaison Committee. Mrs. Price received her diploma at Fairview Park Hospital School of Nursing, Cleveland, Ohio, and her baccalaureate degree from Columbia University, New York. She completed her Masters of Science in Nursing at Frances Payne Bolton School of Nursing, Case Western Reserve University, Cleveland, Ohio.

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CLAIRE V. WOLFE, MD, Mt. Carmel Hospital West and East, Columbus, Ohio. Member of the Task Force on Joint Practice for Physicians and Nurses.

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Pro-Active Planning for Nursing at the Federal Level

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Public Health Service
Department of Health and Human Services
Washington, DC

In addressing the issue of "Thriving or Surviving" with a pro-active approach, I thought of positive approaches rather than negative ones. Also, consideration should be given to the measure of confidence with which we address the issues ahead of us.

I speak from the standpoint of the Division of Nursing, which is considered the focal point for nursing education, practice, and research in the federal government. However, the Division of Nursing is not the only place where nursing activities occur. For example, the Indian Health Service has enormous numbers of nurses scattered throughout the United States with a relatively small staff in the administrative office which is headquartered in the same agency as the Division of Nursing. Another federal agency, the Clinical Center, National Institutes of Health, is a hospital with a large staff of nurses giving direct patient care and participating in nursing research. The National Institute of Mental Health has nurses at St. Elizabeth's Hospital, a major psychiatric hospital in the Washington, D.C. area, that provides direct patient care. In commenting on a specific organization for federal activities in nursing education, practice, and research, we should make explicit that we are talking about the Division of Nursing in the Health Resources and Services Administration.

Although the Division of Nursing is the focal organization, there are three sets of actors involved in planning for nursing at the federal level. These are the profession, the administration, and the Congress. (One adage often quoted is that the President or the Administration "proposes" and Congress "disposes." Another is that Congress tends to react to constituents, global issues, special interest groups, and a variety of other pressures.)

The profession, that is, organized nursing, has long provided leadership in pro-active planning for nursing at the federal level. As early as 1958, the American Nurses' Association was having legislation introduced to support nursing education at the baccalaureate level. Often legislation has to be introduced repeatedly, so that people get accustomed to a particular topic coming before the legislative body. The ANA introduced legislation to support nursing education for several years prior to the introduction of the Nurse Training Act of 1964. When this legislation was introduced in Congress, it fit with the profession's earlier efforts

and priorities, as Congress was already acquainted with some of the terminology and the idea of support for nursing education.

Until recently, that is, up to 1980, nursing had its own legislative bills introduced in Congress to insure that what nursing the profession wanted for nursing was spelled out and could either be enacted or combined with other bills to guarantee the resulting nursing legislation. That is, the ANA, later the Tri-Council, would lobby congressmen and senators to introduce specific legislation for nursing. I mention this because it shows our strength in getting on the record what nursing wants in legislation.

In the September, 1984, American Nurse, the American Nurses' Association's legislative priorities for fiscal year 1985 were spelled out. The ANA legislative priorities are derived from the ANA's National Nursing Agenda for Health Policy, which was published in the latter part of 1983. These priorities are not in order of magnitude, sequence, or importance, but are rather priorities established by the profession for legislation. Federal financing for nursing services addresses areas of importance, which include a federal employee health benefits program, assuring maintenance of essential health care benefits, recognizing and reimbursing the registered nurse as a health care provider, and other areas concerned with nursing services. In addition, the federal role is significant in working to establish a prospective payment mechanism for organized community nursing and nursing centers.

Another priority is access to health care. I emphasize this particularly because when I share with you some of the priorities from the office of the Secretary of Health & Human Services, you will see that there is a change of attitude within the administration. Instead of saying everybody has a right to health care, which is what was being said in the late 60's and 70's, there is now a concern about people having access to care given the resources to provide that care. So one of the ANA's legislative priorities is access to health care by identifying those vulnerable populations with unmet needs for health care and assisting those populations to find nursing services.

Another priority is federal funding for nursing education and nursing research. Two bills are pending right now to provide federal funds for nursing education, and one proposed, in the Senate to provide an increase in support for nursing research. The bills continue to push for federal legislation to insure an adequate supply, utilization, mix, and distribution of nursing manpower to deliver quality services to the public.

Another priority is to promote and seek enhancement of legislation that protects the economic and employment rights of registered nurses. I see this occurring at the state level, since it is this level in government where the economc and employment rights of registered nurses are determined. It was many years ago that activities at the federal level

and efforts of the American Nurses' Association resulted in the Veterans Administration nurses being able to organize. This was an enormous step forward for the Veterans Administration in organizing and dealing with a mass of nursing employees scattered all over the country.

Another important issue is implementation of FY 85 priorities and periodically assessing progress. In recent years, the ANA, the National League for Nursing, and the American Association of Colleges of Nursing have worked together to present to Congress one package of proposals. Differences between and among the three organizations were worked out before "going public." There was a time when the ANA would present its testimony, which was followed by the League's testimony which would be similar, yet somewhat different. Then the AACN got organized and saw itself as THE lobbying group for nursing education: so twice a year they would run their testimony up to the hill. By working together through a Tri-Council formed by the three organizations, they have made a difference in nursing's influence on congressional legislation.

Increasingly, the nursing specialty organizations have presented their members' views to Congress and to the Administration. A recent success story in this area was the nurse anesthetists' organization who obtained trainee funds, which had been approved but not funded. At one point, authorization for the program was deleted, but in the end the program for nurse anesthetist trainee funding was authorized in the Orphan Drug Act. This example shows that anyone watching legislation must watch all of the legislation because legislators can attach amendments to any bill. This amendment was attached to the Orphan Drug Act and received appropriated funds from the Congress last year. So the nurse anesthetists have traineeship funds. Even more recently, in the last few months, nurse anesthetists have succeeded in getting nurse anesthesia costs passed through as a part of the hospital cost for Medicare reimbursement for at least two more years. This all resulted from the targeted activity of one nursing specialty group.

One of the things nursing has to watch out for is keeping all its constituents going in the same direction. This may mean doing a little compromising and bending, but I think it is also important that the nursing specialty organizations have an opportunity to present their views and their concerns. Nursing, on the whole, should try to keep its act together in going to Congress. Clearly, the profession and the administration must look at federal priorities and give consideration both to what has a chance of succeeding legislatively and what is best for nursing. Succeeding in the legislative process involves knowing when to push and when to pull back or when to push and when to ride along. This means we have to look at what is best for nursing in its totality and especially in relation to patient care, rather than nursing in relation to what is good for nurses.

Within the Administration, I am responsible for what the Division of Nursing does, other than legislative initiatives, which may affect proactive planning for nursing even more than the legislative initiatives do. We are part of the Department of Health and Human Services, which is a part of the executive branch of government. Whichever Administration is in the White House sets the parameters for the Departments and what we can and cannot do. For example, when Mr. Carter was in the White House, the position was that there was no shortage of nurses whatsoever, and so staff in the health arena could not go out and say there was a shortage of nurses, whether there actually was or was not. The parameters set by the Administration are publicized in terms of statements, policies, and limitations. When President Reagan came in, his position noted that there was no shortage of nurses in the aggregate, but there were shortages in certain places and of nurses with certain kinds of skills. At present, that is a more realistic picture.

The Division of Nursing is part and parcel of whichever political party is in the White House at the time. The political appointees are set in place at certain levels. Ordinarily, our agency head is a political appointee. We happen to be fortunate that Dr. Robert Graham, who is our agency administrator, is an officer in the Commissioned Corps of the Public Health Service; so he is not a political appointee. That is as far down in our hierarchy as political appointments go.

In the Division of Nursing, we put our recommendations forward for legislative initiatives from the Division, usually to continue all or part of the present programs, in addition to including some new program ideas. Nursing's priorities, however, are considered with all the other priorities in health manpower, beginning in the Health Resources and Services Administration, then the Public Health Service, then the Department of Health and Human Services, and then the Office of Management and Budget. The Office of Management and Budget is a very powerful agency as it is in direct line to the White House. For the most part, the proposals we put forward for legislation get out of the bureau and agency intact; this is a result of our day-to-day work relationship with these people. That is about as far up the line as anybody, up to and including the agency level, can influence it. But the proposals may hit opposition at the Public Health Service level. For this reason, I think the profession must be aggressive in submitting its proposals directly by way of the legislative group. The result that you see may cause you to think that the Division of Nursing should have tried something different. But it is usually not that we didn't try something, but that in the process of massaging the legislative initiatives, items were cut or altered by actions up the line. This happens frequently now in this era of cost savings. Nevertheless, you should remember that the independent operator is the profession; and the opportunity for independent operation belongs to the profession. The Division of Nursing does what it can; yet the result may bear little resemblance to what was initiated.

Last year, Dr. Edward Brandt, who is the Assistant Secretary for Health and head of the Public Health Service, spoke at an agency colloquim. As the head of the Public Health Service, his views are apt to guide what priorities are set internally. He is an appointee of the President and he has the responsibility for the Public Health Service programs, which include all of the health programs--the Centers for Disease Control, the Food and Drug Administration, the Alcohol, Drug Abuse, and Mental Health Administration, the National Institutes of Health, and Health Resources and Services Administration. He said that the goal of the Public Health Service is, in concert with the private sector, to help protect and improve the health of the American people, to help assure reasonable access to health care at a reasonable cost, and to help prevent illness and disease. Priorities, he stated, are the continued expansion of the knowledge base in medicine and health care. I latched onto that phrase because I figured that is a clear statement of support for our efforts to increase nursing research. Thirdly, he said that the PHS needs to reflect on its role as the federal government's primary agency in medicine and health care. I think he was inferring that that role should be decreasing rather than increasing.

More specific priorities in the Administration are pervasive and continuing, such as concern for care of the aged, more attention to educational opportunity for the disadvantaged, and for an adequate supply of health manpower and its appropriate distribution. By adequate supply, we mean a happy medium with not too many and not too few. (It was only as recently in 1980 that the problem was the shortage of nurses.) Appropriate distribution requires that health providers be available where and when they are needed.

Although concerns continue about the cost of health care and cost containment, other priorities can come up rather quickly and get consideration from the Congress. After Senator Percy's committee investigated student loans for repayment of debts for health education, particularly medical and dental education, there has been a big push in debt management and debt collection to get the schools who had the nursing and other health professions loan programs to collect on defaulted student loans. Nobody would complain if the people who borrowed this money repaid the loan as they do to buy a house. If you borrowed money to buy a house and defaulted on your loan you would go into bankruptcy or would lose your house. One individual testified recently that he "couldn't afford to pay more than $50 a month because he had his payments on his $180,000 house, in addition to his three cars and his children's private school tuition." Some of these people have debts of $10,000 to $30,000. That is tax money that has been borrowed. As taxpayers we don't mind their borrowing it, but we want to see them pay it back.

Within the Administration, there are ongoing activities, other than legislative initiatives, that may affect or may influence pro-active planning. One such activity that influences pro-active planning, is the bi-

ennial report to Congress on the supply and requirements for health manpower. These reports go from the Secretary of HHS to the Congress. Nursing continually compiles data for this report which is mandated by law. It is heartening to know that nursing has a little piece in the law that says there shall be a continual compilation of data about nursing supply, requirements, and a variety of other information available on a state-by-state basis.

Special studies, such as the Institute of Medicine study on nursing education, congressionally mandated and carried out under a contract funded by HRSA, are reflected in the fourth report to Congress on nursing. But you must understand that the Division of Nursing cannot make recommendations beyond specifications set forth by the Administration, even though the data would logically lead to other recommendations. For example, when our fourth report to Congress was being written, the President's 1985 budget was already put forward. We could not make recommendations about more professional nurse traineeships when there was no recommendation in the 1985 budget for support for professional nurse traineeships. The President's 1985 budget included support for nurse practitioner, advance nurse training, and special projects grants. After the second or third rounds in the budget-making process, it included some money for nursing research. If the report had been finished sooner, we might have made recommendations in other areas since the budget had not been set, but because of the timing of the process, the report came out after the President's budget had already gone to Congress. We cannot recommend beyond what the President has said are the parameters and the areas of concern for the Administration.

While the Division of Nursing's innovative legislative initiatives may get changed or dropped as they move forward, we do undertake some things directly to identify, clarify, or crystalize issues at the national level. One of the ways we do this is through contracts. Contracts are different from grants. A grant is in response to an application for funds to do something that fits in the categories of support that we have available. A contract is offered when we believe there is an area that needs attention which is not being attended to by the profession or by means of grant monies. And so we offer a contract, which specifies what is to be done, and then schools or commercial consulting firms may bid on the contract. They respond to the proposal and state how and at what cost they would do it.

This fiscal year we have undertaken, by way of a contract, a survey of nursing schools' capacity to meet needs of disadvantaged students. One thing we are falling behind on, particularly in nursing, and in all the other health care educational arenas, is the inclusion of more people from disadvantaged backgrounds. There was a great emphasis on this in the 70's since there was a lot of federal money earmarked for that purpose. A lot was accomplished until the federal money dried up, then people let it go. (I happen to think it is an ethical responsibility for the profession and for the schools of nursing.) What we are trying to do with this contract is to look at the critical mass that has to be in place in an institution

to launch a successful program for training disadvantaged students. Bringing them in is relatively easy. It is much more difficult to help them through to a successful conclusion in which they meet the exit requirements of the institution. We are not talking about changing the exit requirements, but helping those from disadvantaged backgrounds move through to successful completion of a program in nursing.

Of the contract projects just being completed, we will soon have the results of one aimed at developing and evaluating a work-study program to help registered nurses achieve a baccalaureate education, particularly those who come out of disadvantaged backgrounds. There has been an assumption that once a nurse has become an RN, she or he no longer needs any help in moving ahead educationally. The results of this contract will demonstrate the likelihood of getting more RN's though a baccalaureate program more quickly by having an organized program of support.

Another contract is concerned with developing and testing a nursing assessment interview tool to identify self-care behaviors practiced by community-based elderly. Also, the Visiting Nurses Association of Omaha has a contract for Client management information systems for community health nursing agencies. The project builds on other work that the Visiting Nurses Association of Omaha has done in getting usuable community nursing information systems in place.

Another contract, in public health nursing, is in the process of being awarded. They will study the relationship between education and practice in public health nursing. Clearly, we need to attend more to public health nursing preparation and practice.

Recently, we awarded a contract to the School of Nursing at Emory University to develop a neurological-neurosurgical education program for nurses. It will be a short-term training program specifically directed to getting more nurses prepared in neurological-neurosurgical nursing. The Neurological Institute at NIH is providing the funds for the contract and we are administering it. If the project moves along successfully, we are hoping for funds to develop a model or design for a master's program in neurological-neurosurgical nursing.

An RN sample survey is presently underway. The data will be collected this November, so if you receive a questionaire, please fill it in, because the sample is very carefully drawn. It will give us a national picture of nursing. It gives us very accurate information and is the only kind of national data collection on RN's. The Division of Nursing is also completing a survey on licensed practical nurses, the first survey of this group since 1974.

These are the contracts that we have been administering, have underway, and are launching. I consider the sample surveys the most critical contracts that we have in the Division of Nursing, because without the

data, we continue only with "guesstimates," and assumptions. I mentioned the November date of the survey because the questions are asked of the nurse as of a specific date in November so that responses are consistent for the same date. By collecting national data on a certain date, we can compare it nationally as well as state by state.

The Division of Nursing offers conferences which can crystalize or clarify some of the issues facing the profession. This year we had the opportunity to sponsor four conferences. One is going on right now. Normally, they are late in the fiscal year because that is when we know whether or not we have money to sponsor one. We plan the conference when we have the money. Even with a short time line, nurses have been concerned enough to get themselves together, to share their knowledge and their expertise, and to make these conferences productive and worthwhile.

One recent conference examined the criteria for estimating future requirements for nursing resources. The criteria are used with what used to be known as the WICHE State Model, but is now known as the Criterion-Based-Projection Model for staffing. The group has met twice to discuss the criteria. After the first meeting, the staff ran the criteria through the computer with all the figures about population and health services used. In September the consultants met to look at the outcomes of the criteria and the need for any modification. The numbers may appear so enormous that they seem to be generated out of projections now seen as unrealistic, thus requiring modification; or the conferees may look at the data and say, "Yes, the numbers are large but we think they are appropriate." This model is based on the professional judgement, and consensus of experts who determined what ought to be provided to afford quality nursing care. The model is not tied to what presently exists, nor is it a straight-line historical projection.

The second conference convened an expert panel on Collaboration in Education, Practice and Research. We held this conference to get advice from key nurses in the United States on what the Division of Nursing should be doing in the area of collaboration. Was there a role for the Division of Nursing and, if so, what should that role be? What the Division of Nursing does ought to be different from, but should be complementary to what is going on in the profession.

A third conference, co-sponsored with the American Association of Colleges of Nursing, examined the nursing consensus for quality in doctoral programs. This conference attempted to identify indicators that could be used by schools of nursing to assure high quality doctoral education. Presently, there are about 25 schools offering doctoral programs with at least 15 more expecting to admit their first doctoral students by September 1985 for a total of 40. Schools in earlier planning stages must determine: Do we have enough faculty? Do we have enough research under way? What kinds of preparation do we need? What kinds of students should

we recruit? Is there a need to look at geographic distribution? The outcome of this conference will be summarized in a conference report.

The conference which I left yesterday focused on public health nursing practice and education. A chief concern was differentiating between community health nursing and public health nursing. This conference brought together nurses from state health departments, educational institutions, visiting nurse services, and other areas where public health nurses provide education or service. It included nurse representatives from the American Public Health Association, ANA, NLN, the APHA Section on Nursing, the Association of Graduate Faculty and Community Health Nursing, and the Association of State and Territorial Directors of Nursing.

Internal collaborative efforts involve working together in a pro-active direction at the federal level with various agencies, including the National Institutes of Health, and the Public Health Service Task Force on Nursing Research, the Health Resources and Services Administration (HRSA) and the Health Care Financing Administration (HCFA). HRSA, our parent agency, is clearly concerned about preparation of health professionals and at the moment federal funds are still available to hospitals for providing education to health care professionals: residents and interns, nurses, physical therapists, occupational therapists, and respiratory therapists. HRSA and HCFA have initiated a collaborative group to look at the potential impact on health professions education when this educational pass-through to hospitals is deleted from Medicare coverage. It is not a question of whether it will happen, but rather when, unless Congress intervenes. It is clear that HCFA intends to delete these pass-through funds. They are talking about approximately $1.3 billion that has gone into these programs in the past. Although the cutbacks will probably happen, we ought to look at it and try to plan ahead, pro-actively, for federal activities that could be initiated to address it.

In terms of external collaboration, the Division historically has worked with the profession in sharing information, and in reacting to legislative initiatives and ideas. This year, we have met collectively with the Tri-Council and individually with representatives from ANA, NLN, and the AACN to examine and discuss the legislative initiatives that were being put forward. In both decision-making and policy-making, we have collaborated with the National Advisory Council on Nurse Training (NACNT). Although this does not involve planning for nursing, the NACNT has a role as a statutory council whose members are appointed by the Secretary to represent nursing and related fields. There are more nonnurses than nurses on the Council. The Council meets three times a year to advise the head of HRSA and the Secretary of HHS on policy matters regarding nursing and the Division of Nursing. They also serve as the second level review for all the grant proposals received in the Division.

There are probably a thousand other things I might have included about the administration and the executive branch, but I would like to move briefly to the Congress. Congress can indeed be pro-active for nursing at the federal level. For the past several years, no funds have been sought by the Administration for Professional Nurse Traineeships, for the National Research Service Awards, or for research support. Congress not only has appropriated money, but in this fiscal year, they nearly doubled the amount available for research support. (Unfortunately, they omitted including any new staff positions!) Nursing research support increased from $5 million to $9 million, and the increase quintupled the workload for the research staff. The Administration's legislative initiatives did not recommend further support for the health professions and nursing. The Administration's bill for fiscal 85 was never introduced into Congress.

In the meantime, Congress has initiated legislation. The Senate has passed a bill which includes reauthorization of most of the Nurse Training Act. This bill has added some fellowships for faculty, and demonstration projects in the area of special project grants in addition to establishing a Bureau of Nursing with a Center for Nursing Research. The House has a bill before it which includes, renewal of the Nurse Training Act, and the Health Professions Act, renewed support for the National Health Service Corps, and three or four other things. If both bills are passed, the staff of the House and the Senate will have to go to conference to iron out their differences in a compromise bil that will go to the President. We will probably go into fiscal 1985 with a continuing resolution which will give legislative authority and funds after September 30th.

In addition, the Senate has moved its appropriations bill through to its Appropriations Committee and, in spite of the fact that we have no authorization in place, the Senate included appropriations for nursing and health professions and a plan for developing a Center for Nursing research in the Bureau of Health Professions that would include 40 staff positions. At least it puts positions with the money. The House Appropriations Committee would not act on any appropriations for health professions or nursing without authorizing legislation in place.

Congress clearly is taking initiatives in terms of action at the federal level that will determine what kind of legislation nursing will have during this year. The authorizing bills usually provide authority for three years, but the money is appropriated every year. These new bills include support for nurse anesthestist traineeships and include special attention to educating nurse midwives.

The international nursing arena and public health nursing are two areas in which I see little pro-active planning at the federal level. Historically, the Division of Nursing came out of public health nursing and I think that out-of-institution care is one of the burgeoning prospects for the future. The Division of Nursing over the past several years has not done much in the area of public health nursing, partly due to lack of intramural funds. We have program grants funds and we have an

operating budget that supports the staff and the travel, but we do not have any funds for intramural programming, which would permit us to do some things in the area of public health nursing. Nor do I think that the profession has pushed much in terms of this activity. It could be that no activity is needed at the federal level, but it seems to me that we are missing something with public health partly because we are in the U.S. Public Health Service. We try to do some things through our Nursing Practice Branch, but at the federal level--certainly in the Division of Nursing--we are not increasing our activity, influence, or interaction with public health nursing.

I want to close by reminding us that we are nurses in a caring for, caring about discipline. We educate for practice, we do research to improve practice, and we organize nursing services to provide practice. The client/patient who needs us is our sole and only reason for being here. We must guard against being so immersed in concerns for nursing and for ourselves that we appear to be, even if we are not really, self-serving. Please take to heart the advice given to nursing monks in the 14th century:

> "Brother if you are in ecstasy, exalted like St. Peter and St. Paul, or whatever example you wish to take, and you hear that the sick are in need of warm soup or any other assistance, I hereby give you counsel. Leave your meditation immediately and come down to earth and warm the soup."

Nursing and the State Legislature: A Critical Key to our Future

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Introduction: The Nurse Legislator

It certainly is a pleasure to be here and to share my ideas about nursing, politics, and the role that State Legislatures will play in our future. I am particularly pleased to be addressing MAIN, given its focus on the collaboration of nursing education and nursing service for the benefit of all. It is essential that we quit dividing ourselves and that we begin presenting a united front. I see the Midwest Alliance in Nursing as an organization that has reached that realization some time ago and is proceeding forward with the job to be done.

Although I have been a nurse since 1966, I have only been a legislator since the fall election in 1982. Presently there are only 20-25 nurse legislators in the country. I have found myself in somewhat of the unsettling position of being an instant "expert" in the area of nursing, health care, and public policy. I want, therefore, to strip away the label of "expert" and dialogue with you this morning, instead, as a nurse who has served one term as a state legislator and a person who has some definite ideas about what is happening in the health care arena and how this will affect nursing. I hope that through sharing these ideas, I can provide a holistic view of the system; and, at the same time raise some controversy; some discomfort; and cause you to discuss these issues among yourselves during this conference. I trust then that you will take them back home and not only pay much closer attention to what both your state and national legislators are doing for you and to you, but that you will increase your involvement in the process--significantly!

I briefly want to discuss what I used to call the "dual role phenomena" and which I now consider, instead, as a pluralistic role phenomena. I am often asked whether my roles as nurse, educator, legislator, and woman are meshed. The answer to that question is an easy one. Yes, they are very much meshed or interwoven. I feel I contribute a great deal because of my professional background, knowledge, skills, and attitudes. You never leave those things behind because they are very much integrated into your total personality and modes of interaction. The "how" question, however, is a much more subtle and much more difficult one to answer. In the public view, you are seen as a legislator, first and foremost. The job of legislator must become your number one priority during the session, and all else must take second place, if you really want to represent your district well and serve the state. We all do role juggling all the time since we move in and out of roles, combine them or function simultaneously in them.

In the State of North Dakota, we have a citizen's legislature and there are not many "true politicians," if any. I learned to view my colleagues in the House and Senate from a multiple perspective: by party membership (Democrat-Republican); by committee membership; by sex (and of 159 legislators, only 18 or 11.3% were women); and by their profession. So, in addition to the legislator as a person, I saw, for example, a farmer/rancher, a teacher, a small business person, a union/trades person, an attorney, a homemaker, a retired person, etc. There actually were great numbers in these categories as compared to health care providers. I was one of two health care providers, the other being a physical therapist. The same was true of the higher education community. There were two persons from higher education in the House and two in the Senate, and one of the four was me. During the 48th Legislative session, we voted on approximately 1400 bills and resolutions and another 1000 amendments in a 75 day time span. That is about 33.3 times each day on a wide variety of issues from tax policy, to water policy, to health care. Most legislators must rely heavily on others as consultants in their decision-making process and the legislators' professional expertise and biases are utilized heavily in that regard. For assistance in reaching decisions, legislators rely heavily on the decisions of committees; the discussion in caucus; individual discussions on the floor or over coffee; feedback by phone, letter, or direct conversations, with constituents; and floor debate. The latter is probably the least significant because most legislators already have decided by that time, how they will vote.

Because of professional background, philosophy, beliefs, etc., the individual legislator often lobbies--particularly, in their area of expertise. This is done both informally (with groups of friends over coffee, lunch, etc.) and semi-formally (either through sponsorship/co-sponsorship of bills and resolutions or testimony at committee hearings or testimony elsewhere).

In analyzing what the professional gives to other legislators that makes one credible and causes others to utilize him/her, I have arrived at the following list:

1. The first is the most visible and is extremely important--knowledge or expertise. We all need facts and the ability to apply those facts appropriately to a problem. If you accomplish this, you will be credible. Not everyone will agree with you, but they will respect you.

2. Secondly, the professional is a resource. You become a resource both for referral purposes and as a lobbyist in your area. I certainly did not have all the answers, but I could provide the name of a person, a reference, a department, or a resource where the answer could be obtained.

3. Professionalism is next. Most legislators often will review what you say or do as representative of your profession or occu-

pation. You, therefore, need to clarify when your opinion does not represent a general consensus. For example, "Many favor your position but on the other hand, there is a significant group which believes....."

4. Model---This, to me, was an awesome responsibility. Much of what I did, said, reflected, and how I behaved was projected to the entire community that I was viewed as coming from. For example, I was supposed to be smart because I was, after all, a university professor. According to the biases, however, I also should have been so theoretical as to preclude being practical and I also should have been a bit "lazy". I worked hard to overcome these stereotypes. I, additionally, was recognized as "the nurse" and, I believe, that this caused considerable confusion in the minds of legislators. The confusion was due to the fact that I did not match the typical stereotype or the role played out by their cousin, aunt, mother, or the television image. I think this was extremely good. It made them think about the role of nursing and it gave recognition to the multi-faceted nature of the role.

5. Attitude---Probably the least visible, but every bit as critical is the dimension of attitude. It is all-pervasive, but areas of chief concern to me, and the attitudes I tried to carry with me throughout the session, were deeply rooted in my health care experience and my educational background. Seven examples include:

   - Looking at how individuals are affected currently and will be affected by proposed legislation.

   - Giving as much autonomy to individuals as possible, but balancing the needs of society in the formula.

   - Consumer advocacy, not only in health care but also in other areas (I sponsored a consumer utility board bill); and in my attitude toward giving the political sub-divisions as much decision-making authority as possible.

   - A concern for high quality education, as a right for all.

   - A concern for high quality health care, as a right for all, and the use of health care as a broad term, far beyond medical services.

   - A concern, in general, for quality of life issues such as the environment, the nuclear arms race, nuclear waste disposal, etc.

   - Concern for the "disenfranchised" populations, such as the elderly.

In summary, the phenomena of the pluralistic role includes one of bringing knowledge or expertise, being a resource, representing the profession, being a model, and instilling attitudes.

The Health Care System: Policy Directions, Marketplace, Demographics

With the background on my role as a nurse legislator, I want to move to the health care system itself and public policy in relationship to the system. Nursing does not exist in isolation--although, I sometimes feel that the profession views it from that perspective. Nursing is part of a system. We all need to understand that intervention in any part of that system causes change both within the system and to various factors which impinge on the system from outside. Inter-relationships exist within the health care system and among its components, which in turn affect and are affected by the economics and social policy of our country and of our individual states.

The number one public policy question facing governments today is that of access to quality health care versus cost containment. Quality health care is expensive, yet consumers are demanding access to quality health care along with reduction in costs. These demands appear to be incompatible, but are they? If costs are cut, quality will suffer-or will it? That is the problem in a nutshell.

To underline the problem, I would like to tell you about a public survey published in the American Medical News earlier this year (Sticht, 1984). It said, sixty-five percent of those surveyed believed costs were the biggest problem in health care today! Only 14 percent cited quality and 6 percent cited access. But, the same study showed that 53 percent of the respondents believed that we as a society were spending too little on health care. Probably the only conclusions we can draw are that we are not going to solve this problem by taking any more surveys and that the American public does not have clear goals in terms of quality and access as opposed to cost containment.

This was further emphasized to me when I spoke with a constituent earlier this week. She is a bright young woman who is very active in the League for Women Voters in my city. She is a mother of two small children and working toward a doctoral degree at the university. She told me, quite frankly, that cost containment in health care was not a concern of hers. She felt that not enough was spent on health care and as far as she was concerned, health care should be a right for everyone. We need to spend whatever amount of money necessary to secure those rights. Philosophically, I agree with her--but, as a legislator, I wonder, who will pay the bills?!

I think it is important that we understand the public policy toward health care that has dominated in the United States since the turn of the century. Without an historical view, it is difficult to begin to analyze the situation that exists today; and, we cannot intervene without this analysis. The development of a national health policy has progressed

through at least five distinct phases since the turn of the century: (North Dakota State Health Plan, 1982-85).

1. The first stage aimed at improving the quality of care. It was the direct result of the Flexner Report. Shortly after the turn of the century, the federal government contributed large sums of money to educational institutions to improve the training of physicians, primarily, and other medical personnel, secondarily. The effect was to limit the number of schools and strengthen the scientific curriculum. Although the problem of quality was mostly resolved by these interventions, the problem of access began to emerge, due to limited numbers of professionals trained, tougher state licensure requirements, and advances in medical technology causing hospitals to change to large, centrally located facilities with expensive equipment. So, prior to the interventions, we had easy access and poor quality. After, quality increased, but access suffered. This points out how inter-related the system is.

2. The second stage dealt with access. Access to health care, particularly in rural areas, became a national issue immediately following the Second World War. The Hill-Burton Act of 1946 helped finance the construction of hospitals and later, long term care facilities. In 1965, the Medicare and Medicaid Amendments (Titles XVIII and XIX) to the Social Security Act attempted to solve the access problems of the elderly, disabled, and poor. As a result, however, the cost of health care for the population at large was increased.

   Again, we see intervention in one part of the system solving a problem, but simultaneously creating other significant problems. Access in the rural areas and for the elderly and poor improved but, cost became an issue.

3. U.S. health policy then turned to cost. When Medicare was enacted in 1965, government's share of all health related spending was about 12 percent. By 1980, only fifteen years later, state and federal government had become the largest single financier of the health care system, paying 43 percent of all costs. (Health Insurance Association of America, 1981-82) These figures are even more significant when total health care spending is examined both in terms of increase in dollar cost and percentage of the gross national product (GNP). Government has searched for an effective method of controlling health care costs and, at the same time, continued to contribute to the inflation. (Health Care Financing Administration, 1980-82)

Table 1

DECADE	NATIONAL HEALTH CARE COSTS	PERCENT GNP	PERCENT INCREASE BY DECADE
1950	$ 13 Billion	---	---
1960	$ 27 Billion	5.3	107%
1970	$ 75 Billion	7.5	170%
1980	$247 Billion	9.2	230%
1990	$780 Billion	11.5	216% (estimate)

4. Access and cost considered together, was the fourth policy direction. The rising cost of government subsidy of health care and the persistance of access problems made it clear that balance between these efforts was needed. Congress, in 1977, passed the National Health Planning and Resources Development Act. It required states to plan the development of health care resources through state and local planning bodies and to influence the flow of resources in the health care system through a Certificate of Need (CON) law. Under the CON law, major financial expenditures must be formally approved by a governmental body before they are implemented.

5. This brings us to the present policy, pro-competition. In the last few years attempts to inject competition into the health care system have been gaining prominence. With the 1980 Presidential election, pro-competition became national policy. The health care cost problem was redefined as one of too much regulation. The assumption underlying this philosophy is that eliminating the restrictions placed on the health care system by government will restore competition and thus return the health industry to the free market. In addition, however, other free market conditions (not just elimination of regulation) would need to be restored as well.

Underlying these efforts to use free market principles to guide the health care system is the desire to diminish the role of the federal government as a buyer of services. Reduction of the federal role as a financier would serve the dual purpose of reducing federal expenditures and withdrawing federal interference from the proposed free market health care system. The prospective pricing of Medicare services using the Diagnostic Related Groupings (DRG's) is a major movement in this direction. I do, however, see some irony in the amount of regulation which has been instituted in order to eliminate restrictions.

Absence of free market forces

In addition to understanding health policy directions, one must look sat the health care system within the marketplace and the roles which the

government can play. The absence of free market forces in the health economy is responsible, to a large extent, for the alarming growth rate in health care costs. When the health care system is contrasted to the classical free market economic system, several basic factors are missing: (North Dakota State Health Plan, 1982-85)

1. Financial Liability is the first missing factor. In a free market system, the consumer bears the financial responsibility for his/her decisions. In the health care system, this responsibility is limited because the bills are paid by health insurance, Medicare, Medicaid, etc. In reality, business and government have the financial liability.

2. Knowledgeability is the second factor. In a free market system, consumers must be knowledgeable concerning both the quality of products and the prices paid for them. Advertising is the usual means of information. Both knowledgeability and advertising are lacking in the health care system.

3. Competing Sellers also are lacking. For the law of supply and demand to work, there must be an accessible choice between two or more providers of a product who are competing for limited dollars. There is no true price competition in the health care system.

4. Free Entry and Exit is the fourth and final basic factor which is missing. Free entry into the market place and freedom to fail are fundamental to the functioning of free market economics. In the health care system, both are very restricted. Licensure and certification restrict entry and the cost-based reimbursement system tends to hold up the inept or inefficient seller. Free market constraints and incentives are lacking.

When or if a free market system is operating, government has two appropriate functions: (a) the consumer protection function of assuring the accuracy of advertising; and (b) the antitrust function of assuring that buyers or sellers do not indulge in collusion or price fixing.

When a functioning free market is absent, as in the current health care system, the government has two broad policy options: (a) substituting external regulation for the absent market forces; or (b) taking action to create free market forces within the system.

Until 1980, regulation has been the preferred option. Perhaps a third option, a combination of the two, is more viable. That is, reintroducing market forces where possible and substituting government regulation where market forces cannot be effectively employed. (UND School of Medicine, 1970-80)

One must also look at what is occurring in the country in terms of population changes. The effect of changing demographics on the health care system can be a critical element. One example is the population age shift.

The aging of America is placing multiple demands on our society, including the health care sector. From 1970 to 1979, those over 65 years of age increased almost four times as fast as the under 65 year age group (23.5 percent vs. 6.3 percent). More than 11 percent of the total U.S. population is age 65 or greater. By 1990, it is projected that those over 65 will number 32 million and constitute 12.2 percent of the population. (U.S. Department of Commerce, 1983)

In 1978, per capita expenditures for health care services for those over age 65 were $2,026 compared to $597 per person for those under 65. In 1980, this 11.2 percent of the population consumed 29 percent of the health care dollar. It also is important to note that nearly 26 percent of older American lives in or near the poverty level and that is particularly true of older women (who consititute 59 percent of all Americans 65 years or older). Of all older women, 19 percent live in poverty to 11 percent of the men. (U.S. Department of Commerce, 1983)

Given this review, we can ask ourselves, "who is to blame?" Perhaps the most frustrating thing about the health care cost problem is that nobody is to blame. Or, to put it another way, everybody is to blame. (Sticht, 1984)

Let's start with the government. That is always easy. The government is responsible for this problem because of all the Hill-Burton money that built more hospitals than we need and because Medicare and Medicaid encouraged heavy use of those hospitals, and then set payment conditions that did not cover the costs. Government, both state and federal, along with the medical schools also over-reacted to a perceived doctor shortage in the 60's and 70's. Now, we have predictions of an over-supply of physicians.

Lawyers also are an easy target. Malpractice suits became epidemic in the 70's and the award payments themselves were insignificant compared to the costs of the defensive medicine that resulted---more tests than needed, precautionary hospital admissions, unnecessary heroic treatment efforts, and the rest.

We can also blame the doctors and the insurers because the traditional system of "Robin Hood" medicine encourages cost-shifting rather than cost-consciousness. We also can blame them because many doctors do not even know the costs of some of the services they order.

We can blame patients because they are all like me, they demand the best, whatever the cost. It it is my mother, or my son, I am not going to settle for anything but the best care that money can buy regardless of costs.

We can blame the labor unions for demanding comprehensive, first dollar coverage which provides no incentive for either doctors or patients to be concerned about the costs. We can blame management for giving in to them because tax laws made it less expensive than providing the same compensation in the form of wages. And we can blame the insurance companies for administering those contracts with a bias toward in-patient care. Those higher billings often generated larger reserves and profits.

We can blame the hospitals, because of antiquated and inefficient business practices, and because they fill beds to keep revenues coming in. We can blame technology for giving us elaborate new equipment that drives up costs.

We can blame inflation, because it accounts for well over half of the cost rise in health care. (This is my favorite villian). Or sex, because population growth means more demand for health care. Or greed, because there is some fraud in the system. Or we can just wring our hands and blame the system itself.

Everybody is to blame; nobody is to blame.

We must then ask ourselves, "What are we willing to do to decrease costs?" Are we willing to limit or cut back on technology? Are we willing to close hospitals? Are we willing to cut R.N. salaries or substitute lesser prepared and cheaper care givers for R.N.'s? Are we willing to make tough policy decisions such as non-application of life support devices or limiting first-time kidney dialysis to those less than 60 years of age? All have been or are being proposed and/or considered.

I thought one of the more dramatic examples of this schism of thought occurred not too long ago in Congress. As Congress passed the DRG legislation, it simultaneously considered allowing Medicare payment for all organ transplants. In sum, we want it both ways. As a population, the U.S. seems to think it is possible to have it both ways. I am not sure.

Even with the foregoing comments, I do not mean to imply that the system has failed. It has not. By two criteria, the health care system has been remarkably successful. The quality of care is as good or better than anywhere else in the world; and access to that health care has been broadened to include almost everyone. It is only in the area of cost containment that this system has failed. It has failed in spite of one program after another attempting to reign in those costs.

The State Legislatures and Health Care Cost Containment

And, what are the states doing to address this problem? All states are concerned! All are attempting to address these problems.

The National Council of State Legislatures report that in 1983, the states passed more than 285 pieces of legislation aimed at controlling health care costs. Of these newly enacted laws, 218 dealt with six areas: Medicaid, programs for the medically indigent, hospital cost containment, certificate of need, health facilities, regulation, and health insurance regulation. ("Health Care Cost Containment", 1983) I will review each of these six areas briefly. Please consider how each, either directly or indirectly, will affect nursing.

1. Medicaid--Medicaid continued to dominate legislative health agendas in 1983. Unlike 1981, when states reduced or eliminated services, eligibility groups, or reimbursement, 1983 saw a continuation of the 1982 trend towards long-term strategies to reduce costs. States continued to move away from direct service reimbursement systems, instead implementing negotiated pre-paid systems or enrolling recipients in health maintenance organizations. As we look toward the future, I believe that most states will consider carefully the implementation of a prospective reimbursement system for all Medicaid patients in nursing homes. This could have a dramatic effect on nursing just as the DRG system has had in our acute care hospitals. And please remember, we are still seeing cost shifting today. Medicare patients are not our only patients. The DRG system is not an all payor system. Capital expenditures, educational costs, and bad debts are all pass throughs. All payor prospective reimbursement systems are being considered. What then? What happens when we no longer are able to shift costs?

   Strong legislative interest in home and community-based services continued, and maternal-child health services were expanded in several states. In North Dakota, House Bills 1309 and 1314 were examples of the type of legislation enacted. They provided that Medicaid money normally allocated to the payment of nursing home care could be spent, instead, on alternative services to maintain a person in his/her own home and to prevent the elderly and/or disabled from entering nursing homes before necessary. Such alternate services included Home Maker Services, Home Health Aid Services, Chore Services, Respite Care, Foster Care, Boarding Home Care, and other services.

   Idaho broke new ground when it passed a controversial and innovative law requiring families to contribute to the cost of nursing home care for their relatives on Medicaid. North Dakota considered a similar bill in relation to payment by families, on a sliding fee scale, for the cost of care for the institutionalized mentally retarded patients. The bill was defeated by a narrow margin. Look for more of these bills in the future.

2. Medically Indigent--Twelve states enacted legislation in 1983 concerning services for the medically indigent. The medically indigent are those who are financially unable to meet their medical expenses and who do not qualify for assistance under state Medicaid programs. The medically indigent include those with no or inadequate health insurance, and the insured who face indigence as a result of catastrophic medical expenses. In my mind, many of these laws will initially increase health care costs. But, if one views preventive services as ultimately decreasing costs, which I personally believe is an essential mandate, then they can truly be included in the cost containment column. For example, several states passed legislation specifically dealing with maternal and child health services for the indigent. Arizona directed the Department of Health Services to develop programs in perinatal health care, including early pregnancy screening, comprehensive pre-natal care, and maternity, delivery, and post-partum care. Montana authorized the development of programs for nutrition, family planning, prenatal care, and programs authorized under federal block grants to protect the health of mothers and children.

3. Hospital Cost Containment--State legislative efforts to control health care costs were greater in 1983 than in any other recent year. The number of states with mandatory hospital rate setting laws increased by more than a third in 1983 with the addition of West Virginia, Maine, and Wisconsin. This brings to ten the number of states that regulate hospital rates for most or all third party payers.

   In 1984, at least 12 additional states were expected to consider hospital rate setting legislation and I am not aware at this time how many actually passed such laws. In addition, Vermont created a hospital review council and four states enacted legislation dealing with hospital data. (This is often seen as a precursor to the implementation of a prospective reimbursement system). Sixteen states passed bills concerning utilization review, hospital billing procedures, hospital management and ownership, or special hospital cost containment studies. New York, Illinois, and Texas passed laws dealing with mandatory delivery of hospital care to emergency patients.

4. Certificate of Need--In 1983, many states modified their Certificate of Need (CON) programs. The changes that were enacted varied widely, from expanding the list of services and facilities subject to Certificate of Need review at one end of the continuum to providing for the termination of State Certificate of Need programs at the other. Nine states and the District of Columbia made changes in the services and/or facilities subject to this review and six made changes in the administration of their state programs. Six states placed moratoriums on certain types of CON applications in 1983 while New Mexico became the second state, following Idaho in 1982, to allow its Certificate

of Need Law to lapse. Utah will become the third state to terminate the CON law effective December 31, 1984. In general, the tendency of the states in 1983 seemed to be toward loosening Certificate of Need requirements. This often was in the guise of raising the dollar thresholds required for CON review or excluding certain services or facilities from the process.

I think there is a great deal of confusion in relation to Certificate of Need review and how it has been performed. Many feel it has been an ineffective process because it has been circumvented. Others feel that if the laws are strengthened, it could work toward greatly reducing costs in the system. Therefore, we see two opposite movements...but, they are really the same. The strategy is to strengthen the Certificate of Need Law or eliminate it all together. When it is eliminated, however, this does not necessarily mean that the free market is left to operate on its own. Many states are looking at moratoriums. Minnesota is an example. Minnesota has established a moratorium on the addition of new beds into the system. But, in the same law, the legislature made exceptions. Thus, the legislature is now deciding on where and when building should or should not occur in the private sector, rather than leaving these decisions to health systems agencies, SHCC's, or the providers.

5. Health Insurance Regulations--A great deal of activity was seen in the area of health insurance regulation by the states. Florida, Wisconsin, and Virginia joined California in providing preferred provider organization legislation. Preferred provider organizations try to limit the role of the middle man by having companies and/or unions contract directly with physicians and hospitals. Although these are apparently the hottest new item in health care financing, they look very much like the Blue Cross and Blue Shield plans that were formed a number of years back. They are good for the employer because he gets a discount on hospital and medical bills, and they are good for the providers because they can count on a certain patient load. One needs to ask, however, where those costs are shifted?

   In addition, seventeen states passed laws expanding the list of mandated benefits to be included in insurance policies. Only three states passed new laws restricting a benefit which, again, shows the same schism of thought that I referred to earlier in reference to Congress. Four states amended or adopted new laws concerning state risk pools or catastrophic health insurance programs. Examples include the fact that 34 states now require continuation or conversion of group employee health insurance plans; 23 require that mental health services be offered or provided; and 28 require alcholism treatment to be offered or provided.

States also have moved to regulate self-insured group plans which have been exempt from state regulation previously by virtue of the Federal Employee Retirement Income Security Act (ERISA). In this area, we are seeing a movement for states to insure their own employees through self-insurance programs.

6. Health Facilities Regulation--Finally, fourteen states wrote new statutes concerning the regulation of health facilities (not including Certificate of Need legislation). The new laws dealt with home health agencies, hospices, and long-term care facilities.

The Need for Pro-active Involvement by Nursing

Where does nursing stand in relation to the cost issue? This is not an easy question to answer. The issue of third party reimbursement of registered nurse providers is one which can be related directly to the cost issue. Several states allow reimbursement of specific types of nurse providers such as nurse midwives, psychiatric nurses, and/or nurse practitioners. To my knowledge, only four states provide for reimbursement to all registered nurses. They are Maryland, Washington, West Virginia, and most recently, New York. Each piece of legislation has resulted from a long, hard-fought battle to the "victory". Why is this so? I do not believe that nursing has done an adequate job in proving that nurse reimbursement will be cost effective.

I wanted to provide an example and I hope no one will feel "picked on." Just because the example is from North Dakota does not mean the rest of you can breathe easy. As far as I can tell, I could have pulled similar examples from almost any state. I recently have reviewed nineteen pages of testimony provided to the Health Care Innovations Sub-Committee of the interim Industry, Business, and Labor Committee in North Dakota, supporting third party reimbursement for nurses. Three-quarters of one page dealt with the cost of services. No figures were cited. Instead, general concepts were reported. I don't think we made our case and neither did the committee. The State Medical Association testified that reimbursing nurses would cause an increase in health insurance costs and, therefore, increase costs of health care in general. The Committee did not recommend the bill. I think a more effective approach may have been to try to build a coalition with medicine before presenting the bill in committee or to have reached a compromise with them. If that had proved impossible, other coalitions may have been possible--with business, with agriculture, with senior citizens, etc.--more on that later.

I want to comment on how nurses and nursing are viewed by state legislators. This obviously is a very subjective and personal impression. In general, I think nurses are viewed as good people who lack any "sinister motivation", and we often attribute that to other groups, in what they ask for. They are viewed as helpers who provide valuable service throughout the communities. Nurses are respected for what they know and for what

they do. During a severe budget crisis in the State of North Dakota, for example, the only new faculty positions granted throughout the entire state-wide higher education system were for graduate faculty at the College of Nursing at the University of North Dakota. The only new program added at the State Health Department level was that of a nurse geneticist. This leaves me to conclude that nurses' services are highly valued.

On the other hand, however, nursing is not seen as a powerful lobby. It is not viewed as one with a great amount of influence or a group "to fear". In general, at the state level, nursing has been rather unorganized in its approach to the legislative process. This is especially true when compared to our counterparts: organized medicine or the hospital association. We have the numbers to affect a great deal of change-we just have not ever decided to use them effectively. How do we go about doing that? How do we become pro-active?

First of all, nursing needs to work towards consensus within the profession. There is nothing more defeating than a profession divided when it comes to asking for legislative action. Compromise must be obtained within the profession first. Legislators just throw up their hands in total confusion and frustration as they listen to some of our internal squabbles and, if nothing else, this usually results in the maintainence of the status quo. The Maryland Bill in relation to granting of credit toward the Baccalaureate Degree is a good example. It was introduced without consulting the baccalaureate educators and it almost passed despite their objections. The profession needs a consensus approach. We are being harmed by the confusion that we show to others.

Secondly, we also must work toward coalition-building. By this I mean that I see nursing coming to the legislature and asking for whatever seems reasonable and logical to them. Nursing, however, has not talked to others who will be affected or involved and has little idea of who is in support and who is not. I think nursing is often afraid of medicine and, thus avoids discussion with physicians and this may be a great mistake. I think it is often better to fight your battles head-on and to know your opposition. You should know if medicine is to be the opposition or if you can garner support from that sector--before fighting it out in front of a legislative committee. In addition to the medical associations and the hospital associations, there are numerous other groups that nursing should look to in forming coalitions. One of these is the business community and the types of health care coalitions which they are forming throughout the United States. They can be a powerful ally. For instance, I have introduced a bill to change the composition of the State Health Council in North Dakota. This is the state's health policy-making body. It presently consists of eight providers and three consumers. My bill adds four consumers--one representative each from business, labor, agriculture, and senior citizens. On each occasion when this bill has received testimony and hearing, representatives of industry and business from throughout the state have been there to testify in favor. They want a say in health care

policy in the State of North Dakota, because they feel they are paying the bills through the cost of the insurance they purchase for employees. So, although medicine and the hospitals initially opposed this change, they have become very quiet and an interim committee has endorsed this concept.

Coalitions also can be formed with other groups, but this is not pursued actively by nursing. The Farm Bureau and the Farmer's Union are two good examples, particularly for rural states. Senior citizen groups are another as are consumer advocacy groups, women's groups, unions, etc., and the list could go on and on. But nursing continues to go it alone. Let's start talking with these groups and planning with them. We can help them and they can help us.

I also think as a third pro-active measure, that nursing must become more sophisticated in the approach to the legislative process. Nursing must present meaningful facts and be prepared for the opponents' arguments. On the other hand, a committee should not be overwhelmed with unnecessary facts and figures. I have seen both approaches. In general, a legislator is busy; a legislator does not understand the fine points of the issues being presented; and a legislator wants one or two excellent reasons to vote for or against a bill. Therefore, if you have a lot of facts and figures, a one page or shorter summary which refers to appended documents is the better approach.

It also is naive to believe that decisions are made solely on the basis of testimony presented in committee and arguments on the floor. I know that we would all like to believe that logic rules, but this is not always or even usually the case. A great deal of "home work" needs to be done prior to a formal hearing. Meet your local legislators when they are home. Phone them. Let them know what you think. Enlist others to do the same. If you can, work for them. What I am saying is that you should establish and maintain a relationship before you want something. During the hearing process, legislators need to hear from constituents who favor your bill. A legislator wants to be re-elected. If he or she feels that the bill is important to constituents, the legislator will vote for it.

Fourthly, be prepared to compromise. Know clearly what is essential to your bill, the basics; and also know where you are willing to accept trade-offs. Legislation rarely proceeds through the process with no change. Yet, nursing often uses the "purist" approach, i.e. "Do it my way, or not at all." This, in fact, may be your only choice of a position at times. On the other hand, compromose often works. It may result in a better bill. It also may be a "foot in the door". That is, the law is established and gradual change can be made, through amendments and revisions, in the future. Also, do not be discouraged if you lose. It often takes two or three sessions before an idea is accepted and the legislation is passed.

"My" Health Council bill is a good example. In addition to forming coalitions, it is an example of compromise and of a lost bill. It lost during the last session. My original bill, however, removed two providers and added two consumers, creating a six to five provider majority. As now proposed, the eight to seven provider majority will accomplish the same goal of greater consumer input into decision-making, without creating opposition from medicine and the hospitals--who both would have lost one of their two members. And, most agree that consumer and provider input is evenly divided since nursing has a provider seat. Nursing is viewed as a consumer advocate.

As a last measure, I think that practitioners of nursing must be convinced that spending money, time, and energy on political and legislative efforts are worth it. As nursing leaders--in both education and service--I see that as your challenge. You must create the motivation, and provide the example, leadership, and encouragement.

In closing, I would like to say that health care is a public policy issue, and one involving competition among five strong interest groups--consumers, insurers, government, providers, and business. Each has the same objectives: to reap the benefits and avoid the costs. Each is looking for it's own "solution" to the problem. Our best possible result won't be a single "solution", however, but an acceptable compromise among these five competing interests. It will be one that addresses not just our current situations, but also our future needs. It is important for us not only to understand ourselves as a profession and know where we want to see the health care system evolve, but also to understand our competitor groups and their specific goals and objectives. Only in that way can we forge the kinds of coalitions needed to move toward a suitable compromise.

I believe that the amount of health care we need as a society will be determined by how much the major interest groups are willing to pay. I do not believe that the various competing interest groups will be equally powerful in engineering the compromise concensus that is inevitable. I believe government and business will have more to say about it than the others because they have more control over the purse strings, and money is the issue here. I believe the health care professionals should be actively involved now, or risk being left out. We must work together,--as nurses, as members of a health care team, as health professionals.

REFERENCES

Compiled from U.S. Department of Commerce, Bureau of the Census, Current Population Reports, various years; Statistical Abstract of the United States, 1981; and data compiled by the Office of Rural and Health, University of North Dakota School of Medicine, 1983.

Health Care Cost Containment, 1983 Legislative Update, Fifty States. National Conference of State Legislatures, Denver, Colorado, December, 1983.

Health Insurance Association of America, Source Book of Health Insurance Data 1981-1982, p. 53.

Health Care Financing Administration, DHHS, Health Care Financing Review,, Winter, 1980; September 1981; Winter, 1981; and March, 1982.

North Dakota State Health Plan, 1982-85, Statewide Health Coordinating Council, North Dakota State Department of Health, Bismarck, North Dakota, pp. 1-4, 11-14, 16-17.

Statistics compiled by the Office of Rural Health, University of North Dakota School of Medicine, from Census of the Population Bureau of Census, 1970 and 1980.

Sticht, Paul J. "Remarks", unpublished paper, presented to the Association of American Medical Colleges, Callaway Gardens, Pine Mountain, Georgia, April 2, 1984, p. 2-3.

Pro-Activating a Collaborative Service Education Climate

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This presentation is divided into two parts. First, there is a general overview of the Frances Payne Bolton School of Nursing including an historical account of the collaborative relationship with University Hospitals of Cleveland Department of Nursing. In the second part, we describe some recent changes in perspective of the University Hospitals of Cleveland Nursing Department with reference to implementation of the collaboration model. We wish to share our enthusiasm about these changes because we not only perceive them as proactive but as evolutionary, if not revolutionary. Clearly they are changes that will help to propel us as professionals to new goals and new heights. We are proud to be involved in a major redesign of nursing care. We applaud the efforts of those who are also currently involved in such changes; and we encourage those of you who seek advice and/or support in such re-direction to be heartened by our success.

The School of Nursing

Frances Payne Bolton School of Nursing is part of a small private university, Case Western Reserve University (CWRU), with approximately 5,000 of the 8,500 students seeking graduate or professional degrees. The School of Nursing is part of a Health Science Center which is contiguous with University Hospitals of Cleveland (UHC), a private corporation. Even though it bears the name University, it is not owned or directly managed by CWRU.

In its philosophy, the faculty of the School of Nursing include the belief that nursing is an academic discipline and a profession. Nursing, as an academic discipline, is a distinctive branch of human knowledge fundamental to nursing practice, education, administration, and the continuous development of the profession. There is a strong academic focus on knowledge development and academic scholarship within the School of Nursing. Three educational programs are offered: the MSN degree which prepares nurses for advanced specialty practice, the ND (nurse doctorate) which prepares individuals for advanced practice at the professional doctorate level, and the PhD, the research doctorate.

Since 1966 there has been an organized and formal interinstitutional agreement between the Frances Payne Bolton School of Nursing and University Hospitals of Cleveland. The goals of this relationship are quality nursing care to patients, an exemplary learning climate for students of nursing and nursing staff, and the development of research in nursing practice. This relationship is formalized by the shared appointments of key leadership people between the school and hospital nursing department, the appointment of qualified faculty to hospital associate status and qualified nursing staff to the clinical faculty. Specifically, leadership persons for faculty groups, such as maternity nursing, hold 50-50 appointments as chairperson directors of that specific clinical nursing service. Thus they are responsible for leadership in both the academic and service settings, sharing leadership roles in education, research, and professional practice. Nursing personnel appointed to any leadership position at University Hospitals of Cleveland are recruited through an academic search and are approved for appointment through the Appointment, Reappointment, Promotion and Tenure Committee of the School of Nursing. These clinical faculty members are intimately involved in the various educational programs of our students and they participate actively in the faculty structure and organization.

The emphasis on clinical nursing is a major strength of the educational programs. One of the main objectives of this collaboration model is to provide an exemplary learning climate. Our students have first hand exposure to the cooperative environment created by these professionals. Nurses involved in academic nursing and those involved in nursing service are joined here in a unique way. Relationships are mutually enhancing, and there is a spirit of excitement and involvement among all professional nurses.

Rozella M. Schlotfeldt, one of the key figures in design of this collaborative model, recently identified five principles that guided its development toward the realized goals (1984). These include:

1. Higher education institutions preparing health care professionals and the health care agencies in which high quality health care is provided are interdependent. Health professionals cannot be prepared independent of the service delivery settings. Successive generations of practitioners must be prepared for leadership in advancing knowledge and improving practice.

2. There is a need in both institutions to have sufficient numbers of well qualified, highly competent, humane and sensitive, self confident practitioner-teacher-investigators to provide excellent programs of care and education. The programs must reflect knowledge not only in its state of the art, current state, but also in the characteristic "cutting edge." The persons involved need and desire the scholarship that prevails in universities and health science complexes. In the FPB-UHC Model both insti-

tutions have excellent records relative to recruiting and retaining well qualified appointees at all levels.

3. Basic and clinical research provide the firm foundation for continuous advancement, verification, and clarification of knowledge fundamental to professional practice and essential to effective socialization of professionals. The nursing research programs of our two institutions have steadily grown in sophistication and diversity.

4. Successful leadership in complex institutions subscribe and facilitate the decentralization of authority and responsibility. We are all professionals responsible for the design and execution of differentiated and specialized programs of nursing practice, nursing education, and clinical nursing research. Our model is frequently cited for its success in achieving goals of providing high quality nursing care, offering excellent educational programs, and contributing to nursing's advancing science.

5. The interinstitutional relationships among agencies should enhance the unique goals of each participant institution as well as the goals they share. The primary goals of the university are to educate students and to advance knowledge. The primary goal of the hospital is to deliver high quality health care and services. The goals of each are enhanced through our collaboration model.

For over two decades we have maintained a collaborative relationship in the education of nursing students, the provision of quality nursing care to patients, and the generation of nursing knowledge through research. The health care and economic arenas of today, however, are vastly different from those of the 1960s when the model was developed. Today's climate requires a delicate balance of stability and change, tradition and innovation. We are functioning in an era of rapidly expanding knowledge coupled with financial restraint. Our design has been aimed at modifications intended to preserve and enhance the ability of professionals in both institutions, to achieve our common mission in a collaborative mode.

The Hospital

Consideration of the purpose of an organization is a necessary prelude to the shaping of that organization. In the case of a hospital nursing service, its first and foremost purpose is to provide direct, personal services to patients. In Virginia Henderson's words (1966):

> "Nursing is primarily helping people (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will, or knowledge. It is likewise the unique contribution of nursing to help people to be independent of such assistance as soon as possible."

University Hospitals of Cleveland, in addition to adhering to this primary mission of patient care, participates in the development of the next generation of individuals who will give this care and the development of new methods of giving care.

Since the doors of the hospital opened in 1898, on Lakeside Avenue in Cleveland, there has been a very formal, integrated relationship between the provision of nursing service and the education of nurses. Isabel Hampton Robb, co-founder, and first President of the American Nurses' Association, co-founder of the National League for Nursing, and co-founder of the American Journal of Nursing and first matron of nursing at Johns Hopkins Hospital, said, at the building dedication (1898):

> "As a nurse with keen interest, I take particular pleasure in assisting at the opening of the Lakeside Hospital because it is the first hospital on record supported by private contributions that opens its school for nurses upon a purely educational basis. The fact that the Trustees of the Hospital, in its construction, in sanitary arrangements, have given every thought to the care and well-being of the patient, augurs well for the fulfillment of the obligations which they have taken upon themselves in accepting pupils in their training school."

More recently, some have criticized the methods used by nurses in providing care because much of nursing care is not based on sound research or theoretical principles. The hospital is committed to assist in the development of scientific principles upon which nursing care is to be predicated. The hospital then, has three missions, patient care--its primary focus; active participation in nursing education; and the development of new knowledge in nursing.

Louis Sullivan, the famed Chicago architect and teacher of Frank Lloyd Wright, coined a phase which we think is appropriate to apply to our consideration of nursing organization. Sullivan said: "Form follows function." So it is with the structure of a hospital nursing service. Its form must follow its function. The functions have been outlined above. We will show how form flows from each of these three functions, or missions.

First and most importantly is patient care. Nursing is as much an intellectual endeavor as it is a physical one. To decide what to do for a person requires considerable knowledge applied in some orderly manner. The nursing process is a common framework for conceptualizing nursing care. Through this method, a nurse assesses a person's need for nursing care, plans the care, implements the planned care, and evaluates its result in resolving the patient's problem. Patient assessment is the most crucial step, because all care flows from assessed patient need. In each contact between nurse and patient, the nurse analyzes and judges what is to be said and what is to be done. No nursing is given by rote or routine, rather, some specifically observed or perceived need dictates all care provided.

A registered nurse, in an assessment crucial to all subsequent action, assembles data from the patient, family, physician, nurses, and hospital record. In synthesizing this information, the nurse makes summary statements about the patient's condition. Some call the end product of this assessment the patient's nursing diagnosis. Whatever it is called, this intellectual work is the essence of nursing. The work is done by registered nurse professionals who are educated, tested, and certified to be capable of undertaking this intellectual process.

This is in contrast with functional or team assignment nursing care delivery models, which are the traditional and more common models for allocating work in American hospitals. In the functional or team models the principal duty assigned to staff nurses often deters them from the continuity of sustained contact with patients and limits their ability to engage in patient assessment. When registered nurses are required to delegate patient care to licensed practical nurses and aides, opportunities for nurses to employ the intellectual processes are lost. These patient care models are common where the majority of hands-on, care-giving nursing staff are not registered nurses (a fact of life in most American hospitals), which serves to frustrate the professional practice of nursing. To achieve our primary patient care mission at University Hospitals of Cleveland, we determined that a predominantly, if not all, registered nurse staff, is required to give patients the professional nursing we envisioned; and that care should be organized using a case assignment method. The term "primary nursing" is used frequently to describe care organized using case assignments. Case assignment and predominance of registered nurses on the staff constitute the ward-level organization model at University Hospitals. This flows directly from the function calling for professional nurses to exercise clinical judgement on behalf of their patients.

The second of the three missions is nursing education. Education is a very complicated process, occurring in several dimensions. The education of the nurses that University Hospitals employs is one dimension; and the education of students in the nursing educational programs of the Frances Payne Bolton School of Nursing, Case Western Reserve University, is another. It has been our objective since 1966, at the onset of the collaboration model, to combine these two efforts utilizing the skills of well-prepared, knowledgeable, clinical nurse specialists, titled Clinicians.

The clinicians employed at University Hospitals of Cleveland, serve two functional areas: staff development, and clinical nurse specialist positions. In staff development, the direct objectives are to enhance practice through working with employed staff. The objectives of the clinical nurse specialists are to impact directly on patient care, and do this in such a manner that they serve as role models and teachers to both staff and nursing students. In the last several years, we have increased the proportion of clinical nurse specialists and decreased the complement of staff development instructors. It is our view that, in a practice profession, staff development functions flow directly from the expert

ministrations of acknowledged leaders in nursing practice. The selection of organizational form including the numbers, staffing levels, and educational qualifications, have emanated directly from our nursing education mission. We have over 100 master's and doctorally prepared clinicians in staff and leadership roles who participate in the educational activities of student nurses at the ND, MSN, and PhD level. These same individuals actively participate in the development of staff, many of whom are graduates of the programs of the Frances Payne Bolton School of Nursing.

It is, of course, our objective, to integrate the educational processes for new graduate nurses and for student nurses into a continuum. We would prefer to keep these two dimensions of nursing education closely aligned, despite the fact that one pays tuition and the other is paid a salary. Nurses attracted to work in this educational environment are typically college graduate nurses, who frequently go on to study nursing at the MSN, or PhD level. The adoption of an educational mission has enhanced our patient care function. The nurses employed at University Hospitals of Cleveland, by any measure, are the most well-prepared nurses in the country.

The third mission of University Hospitals of Cleveland Nursing Service, is the generation of new knowledge in nursing. This area is the one that needs the most development and has been the focus of our reorganizational activity over the past several years. Since 1966, the hospital nursing service has been decentralized into clinical areas. They include Medical-Surgical Nursing, Psychiatric Nursing, Nursing Care of Children, Maternity-Gynecologic Nursing, and Operating-Recovery Room Nursing. In each case, the individual responsible for this decentralized unit was an advanced practitioner of nursing, prepared minimally at the master's level, and commonly at the PhD level. These individuals are also Chairpersons (where positions existed) of faculty groups in the nursing school. The Director of Medical-Surgical Nursing is also the Chairperson of the Medical-Surgical Nursing faculty group at the School of Nursing. Because of the needs of the hospitals in 1966, and in the decade that followed, the individuals in these positions concentrated their energies in developing the hospital Nursing Service through the management of the various clinical nursing departments of the hospital. That clearly was the priority at the outset of the collaboration model. The individuals who have been working in these positions since 1966 have done a stellar job in shaping the various clinical nursing entities at University Hospital of Cleveland.

Since 1981, however, Case Western Reserve University has insisted that nursing faculty meet the same criteria for advancement and promotion in the University system as all other faculty members in the other components of the University. For a small private research university this means "publish or perish." Beginning in 1980, the CWRU School of Nursing and the Hospital have been acting in tandem to insure that the scholarly output of the faculty of the Nursing School is at a level comparable to other units in the University. As Chairpersons of faculty groups in the School of Nursing, the Directors in the Hospitals were asked to re-focus

on developing themselves and others in the performance of activities that could most appropriately be done by individuals with doctoral preparation. To that end, the Hospital Nursing Service has worked on the development of the role of second-level nurse administrator, titled Assistant Director, who could assume responsibilities for operations of the Hospital Nursing Service. The individuals who were to assume Assistant Director roles were already competent and eager to assume these responsibilities because of the exposure and example that had been set by the Director/Chairpersons. This latest variation in our organizational structure facilitates the performance of nursing research in the clinical setting. It is our expectation that the Director/Chairperson will exert leadership in the research area and facilitate both regular and clinical faculty performance of clinical nursing research in the hospital setting.

Form does follow function. At University Hospitals and Case Western Reserve University, where patient care is coupled with nursing education and research, the talents of the personnel in the organization are fully utilized to facilitate optimum patient care while at the same time offering the best possible nursing educational experience available. This means nursing educators and clinicians work together to ensure the patient care and educational objectives are achieved. The dynamic collaboration model, long in use at University Hospitals of Cleveland and Case Western Reserve University, can serve as a model for replication wherever nursing leaders are inclined to meld service and educational missions.

References

Henderson, V. The Nature of Nursing, New York: Macmillan, 1966.

Robb, I. H. Dedication speech Lakeside Hospital, Cleveland, OH 1898.

Schlotfeldt, R. M. Letter of nomination for MAIN Achievement Award, 1984.

Question:

I am JoAnn Macklebust, Harper-Grace Hospital, Detroit. I am directing my question to Dr. Halloran. Do you differentiate levels of registered nurses at University Hospitals of Cleveland? As one of the members of the Detroit Demonstration Center for MAIN's Associate Degree Nursing project, I wonder if you could elaborate on differentiation of levels in your institution.

Dr. Halloran

I do not mean to imply that we restrict our employment to persons prepared at the baccalaureate level. For example, we actively recruit diploma graduates, associate degree graduates, and doctorally prepared nurses from the ND, as well as baccalaureate nurses. We, in fact, distinguish them with different job descriptions, different standards, and different pay scales. But, we do consider them all to be registered professional nurses as defined by Ohio's statute. I do not want to get into the differentiation that we have done between registered nurses and licensed practical nurses and aides because that creates great disunity and disharmony in nursing. We consider, for the purposes of our employment, all persons qualified as registered nurses to be capable of providing primary nursing to patients.

Question:

Madeline Zaworski, Lorain Community Hospital, Ohio. To carry that same thinking farther, as you look at all-RN staffing patterns on the various wards in your agency, do you also look at the number of baccalaureates and number of associate degree nurses in relation to assignment of patient care?

Dr. Halloran:

What we look at is the needs of patients. It has been my experience in measuring degrees of difficulty of patient care--acuity or whatever term you use to describe the level of knowledge and skill needed--that there is substantial variation in the requirement for nursing services. In fact, there are relatively few patients that have extraordinary demands since most patients have an average demand and some patients have very little demand for nursing services. This equates nicely with the distribution of the educational preparation of our nurses. We have relatively few nurses who have advanced preparation in clinical specialties in nursing and, using them to take care of our most difficult cases is a priority. By looking at our patients first, we attempt to make a match between the skills of the nurse and the requirements of the patient for nursing care.

Dr. Fitzpatrick:

I had some specific comments to make about changes that we have initiated. We have talked very generally about the principles guiding our changes, but let me give you two examples of some specific changes.

At our university, an earned doctorate is required for appointment to the rank of assistant professor. However, we have a strong belief

that because most professional nurses are prepared at less than the earned doctorate rank and because professional nursing, in fact, requires a different kind of preparation than some other academic disciplines, a different kind of academic rank is needed for them. Therefore, we have just designed a rank within our faculty appointment and tenure criteria which permits the appointment to our clinical faculty of baccalaureate-prepared professional nurses. And we have initiated the appointment to our clinical faculty of some baccalaureate-prepared nurses in our collaborative service setting. This is the beginning of our movement to pull in more baccalaureate-prepared and professionally-prepared nurses at all levels into the clinical teaching of our students. This is a specific example of what we have done to make a difference in our setting. We anticipate that this activity will grow and expand as more and more staff nurses participate in teaching our students.

Secondly, we have an active research program. One of our staff nurses at University hospitals has initiated a new research project in patient incontinence--an area of priority for nursing research. To provide support for her and her project, we initiated and maintained a clinical faculty appointment for her so that she could have access to the resources of the School of Nursing that support research and scholarship. In addition, the hospital provided financial support for her research. This is a specific example of how we have initiated this change.

Also, related to our research program, two years ago we started a graduate assistant program that provides some financial support for doctoral students to assist faculty in research. Essentially, it follows the model used in our disciplines in that the graduate assistantship is part of the doctoral experience in which the student becomes socialized into the academic role and works with a faculty member on specific research projects. When we initiated the graduate assistant program within the School of Nursing, we approached University Hospitals' Nursing Department to ask if they wanted to join us in that endeavor, and, in fact, the directors of the clinical departments, the Director/Chairpersons, and Dr. Halloran generated three positions for graduate assistants who were then jointly assigned to research projects in the School of Nursing and in the hospital. They helped us bridge the gap between the regular and clinical faculty, and the educational program and the service setting. We have made research monies equally available to clinical faculty and to regular faculty. We are trying hard not to discriminate on the basis of whether or not your paycheck happens to come from University Hospitals or whether it comes from CWRU, and indeed, are moving closer to a collaboration in the area of scholarship and research.

We have other joint projects among clinical faculty based at University Hospitals, as well as among staff nurses and faculty members who need the entree into the clinical settings for research purposes. Those of you who have worked in settings that do not have a collaboration model will appreciate how difficult it is as a researcher to get access to patients through the system. It is probably the most difficult thing to do in

initiating clinical nursing research if there is no direct link to a clinical agency. Because of our collaboration, we do not have that problem at all. That is Utopia for a researcher!

Question:

Steve Burns, Elmhurst Memorial Hospital, Illinois. For those of us in nursing administration who are trying to promote baccalaureate education for all of our staff who do not have the pleasure of being affiliated with a direct source of BSN students, do you differentiate between those nurses who go for baccalaureate education in health arts, psychology, sociology, or whatever, from the ones who go for the baccalaureate in nursing? Do you promote that?

Dr. Halloran:

Hospital nursing service has a very, very modest contribution to make toward the educational advancement of staff nurses. It is the same for every member of the staff and it makes no difference in which program you enroll. It is administered totally by the hospital; it really has nothing to do with the School of Nursing at all. I have been chided by my colleague to have the hospital increase its tuition aid program because the school's tuition is out of sight. But that is the nature of the type of school. Nonetheless, we do not make any differentiation and we do support individuals who study not only at the Frances Payne Bolton School of Nursing, which is the most common choice, but also those who go to Kent State University for nursing courses, Cleveland State University, and other places. We had a very active program in upgrading some of our practical nurses to RN's by committing funds to help them attend community colleges and the like. We give an awful lot of encouragement; but we have not been able to provide much financial support for education.

Question:

Luann Roland, St. Vincent Medical Center, Toledo, Ohio. Keeping in mind the comments that the previous speaker adressed about a consensus as we go before the legislature, University Hospitals of Cleveland, as well as many in the Toledo area, have been moving quickly toward a professional model, and in that process have been laying off LPN's. I am finding that this group of individuals is a very vocal constituent of the nursing profession, and as we go before the legislature in Ohio to develop a new Nurse Practice Act, I am wondering if you can suggest some strategies to diffuse some of this anger, to address some of these individuals' problems as a group within the nursing profession?

Dr. Halloran:

I have one comment to make. As I mentioned to you something about the composition of nursing staffs in American hospitals, I am reading a book written by Bruce Ladek called Unloving Care. He recommends that you look at the statistics about who takes care of patients in nursing homes. I think there is an extraordinary shortage of registered nurses and I think that will continue for the next several hundred years as I look at the situation. It relates to the dependency, the increased dependency, of

people on purchased services. Those purchased services are institutional in form, in some cases like hospitals and nursing homes, but increasingly they are going to be provided in the home and in other forms.

I think the nursing profession ought to be taking a position about the standards of care for both nursing homes and for home care and other dimensions of care, because if we do not do that the least expensive, least prepared person, is going to be put in the position of providing nursing care. Although people tend to define what is needed as assistance with hygiene or activities of daily living, and give very little priority to those activities, if you look at American nursing homes where there is an absence of professional nursing, whether it be practical nurses or registered nurses, I find that most people are not very satisfied with the care that they get there, and most people that look in the windows say that they do not want to have any part of being there. So, again, I think that there is a very important role for both professional and practical nurses, both are roles in transition which I do not think should last forever.

There is plenty of employment opportunity to work in those kinds of settings. I think we ought to assist them in insisting that the standards for nursing care in nursing homes be changed.

I would like to make an additional comment about that from the educational perspective. I think we have been elitist in our educational programs and that it is time we stop doing that and make other options available to individuals. I know that some well-qualified people are still being recruited into LPN programs and other kinds of educational programs where they should not be. I think that it is our fault; we have been unethical, in fact, in some of our educational pursuits of maintaining certain programs for the short-range good of the institution, rather than the long-range good of the profession or of the society. It appalls me that some highly qualified individuals are not aware of the educational opportunities available to them, and are not apprised of these opportunities by our nursing educators. We need to help people if they have made a choice that is not appropriate to their background and previous education through a practical nursing program to help them move more quickly into the mainstream, or help them find those places which will provide some transition for them in the job market.

Question:

Inez Hinsvark, University of North Dakota. I would like to say a few words about this last question. There is a large group of LPN's who are being laid off from the hospitals. This will happen of course in nursing homes, too, and they see this trend clearly. They have presented a position paper to publish through their national organization which states that they would like to have their education upgraded to the associate degree level. This will be pushed by the organization and, indeed, in North Dakota we have taken a stand on this. I think that politically the nursing profession had better take into consideration this very large

group and draw them into the circle. We really can no longer afford to ignore them. I think schools of nursing are going to have to open the doors so that these nurses can have a better education, and so they can be employed if we are to get the public support that we want.

We have worked together with the Board of Higher Education, the Board of Nursing, the Practical Nursing Association, the Professional Nursing Association, and all of the educational institutions in North Dakota, and as a result the Board of Nursing will be upgrading its rules and regulations so that LPN's will henceforth need to have the associate degree. That means that all our associate degree programs will have to decide whether they are going to be programs for upgrading the LPN or for preparation of the technical RN. These will be based on competencies that are quite different from the LPN of today. It does mean that we will have to have program articulation and we will have to consider the technical component within the LPN programs or the new associate degree programs so that it will fit into the professional program. I support this action. I have been in nursing and nursing education for a long, long time, and I have seen this movement coming for a long time. If we really want unity, that is the way we will get it. We need to draw a big circle and draw all of nursing into it.

Question:

Carol Karrer, Franklin University, Columbus, Ohio. Also to answer your question and pull together the preceding speakers' comments, I have been very fortunate for the past couple of years to be a delegate to the coalition to revise the Nurse Practice Act in Ohio. Those of you from other states might be interested in watching what happens here. We went out on a limb several years ago and were fairly prominent in the literature because of our dissension within the state. From this we have really made an earnest effort in response to the legislators to "get our act together before we knock on their door again." We have spent two years in a coalition of nursing organizations within the state. Some 17 organizations very patiently talking together and one of the strategies they used was to organize four major committees, and interestingly enough, the chairmanship of two of those four committees are people associated with the LPN organization. One is the executive director of the LPN Association in Ohio and another one is a person who has been an LPN for a long time and very active in the LPN circle within the state. The additional composition of those committees included some extremely competent, well-prepared people, including a nurse lawyer. The critical thing was the balance of representation on the committee which has been very carefully thought out in an attempt to maintain and improve nursing standards within the state. They are talking about where we are headed in terms of future directions, but at the same time not discounting anyone.

From Tension to Teamwork: Promoting Positive Interprofessional Relationships

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Geraldine Price:

We have a broad spectrum of nursing practice problems in Ohio as do many other states in the Midwest area. Our State Medical Board believes that some nurses are engaged in the practice of medicine while our State Nursing Board believes these same nurses, performing these same tasks, are engaged in the practice of nursing.

This issue went to court when the Medical Board brought charges against a nurse who was employed by a health maintenance organization (HMO). The case, The State Medical Board v. Health One, involved an HMO in Columbus. Co-defendants included The Ohio Nurses' Association and the Board of Nursing while the Ohio State Medical Association joined sides with the Medical Board as plaintiff.

After several hearing dates were delayed, the case was settled out of court. The HMO agreed that the nurse would no longer perform breast exams, PAP smears and pelvic examinations. The Medical Board and the Ohio State Medical Association then decided voluntarily to dismiss the case against the co-defendants.

This whole issue of the specific procedures opposed by the Medical Board is a real concern to the Ohio Department of Health due to the number of family planning clinics funded through the Ohio Department of Health.

The Ohio Department of Health believes that practice issues should be decided by the professions, rather than the courts. A task force was appointed by the Director of Health to produce a statement or document that could be used by both professions in working toward a solution which would ultimately produce public policy.

This six-member task force consists of a representative from the State Medical Board and the State Nursing Board, the Ohio Nurses' Association, and the Ohio State Medical Association, in addition to a nursing and medical educator. The chair is neither a nurse nor a physician, and she along with the Director of Health, and I are considered participating staff.

The task force agrees that nursing and medicine place emphasis on different but complementary and overlapping spheres of health care, but we are constantly confronted with a language problem. The words "assessment, treatment, and prevention," and the phrases "health maintenance and health education" seem to mean the same thing to both physicians and nurses.

It has been especially difficult and frustrating to try to understand the physicians' concerns about nurses' use of words, such as, "practice, diagnosis, independent, collaboration, supervision, and client." During our discussions, the physicians tend to work toward trying to eliminate these words from our statements or our documents including any kind of language that would bring up a negative reaction among physicians. On the other hand, nurses seem to be working toward including language that is commonly used in nursing. One example is the word "practice." Physicians have become accustomed to using the word to mean what they enter into after their post-graduate training. That is, the establishment or setting up of a practice. On the other hand, nurses use the same word to describe what they do as nurses. That is, they practice nursing, or enter the field of nursing practice. We, as nurses, use the phrase "independent practice" when we set up a practice, while physicians use the phrase "sole practice, group practice, or private practice." So we are using the words somewhat differently.

The second example involves the word "diagnosis." Physicians interpret the word as the decision about a patient's medical condition. Nurses use the word in a similar manner to identify their decision regarding outcomes of a nursing assessment. While nursing diagnosis is accepted and widely used in nursing service and education, it seems that only recently physicians have been introduced to its meaning and use.

So far, we have had four meetings. I believe there is less "ownership" of words on the physicians' part and greater understanding of the implications of language use on the nurses' part at least within the task force. Nevertheless the language issue is a real problem throughout the state as far as nurses and physicians are concerned.

The issue of roles and relationships in primary health care has permeated all our discussions. While there is agreement that both medicine and nursing have a role to play, defining their role in ambiguous words that are likely to be misinterpreted by both professions has been a real stumbling block. The group has reached consensus that nurses do provide primary health care and that both professions engage in wellness care. The tension arises in recognizing that nurses are seeing patients who come to them because they are not feeling well or have a specific complaint.

There does not seem to be any problem with nurses giving primary health care to well people and keeping them well. It is when they come to the nurse with a specific complaint and are not feeling well that opinions differ. Nurses feel confident that appropriate referrals are made to physicians for medical diagnosis in these situations; however, physicians do not have the same degree of confidence. They worry that a medical diagnosis is going to be missed due to the nurse lacking the necessary medical perceptions and not making a referral.

Along with the entry into the health care system, we have to consider the variations in educational preparations of nurses, which poses a major stumbling block. Can we honestly say that all nurses are equipped to provide primary health care? If not, how does the consumer determine which nurses are qualified and which nurses are not?

In any discussion of the scope of practice, the topic of who can carry out specific procedures arises. We are trying to develop a document that can serve as a basis in principles for making decisions about specifics. PAP smears, breast exams and pelvic exams are three specific procedures which come up frequently. There is agreement that PAP smears and breast exams are within the scope of nursing practice. Disagreement occurs in regard to pelvic exams.

At one of our meetings, the Ohio Nurses' Association and State Board Representatives brought in samples of questions nurses ask about the legality of performing such procedures as, lumbar punctures, bone marrow biopsies, adminstering anesthesia without being certified, and serving as first assistant in the operating room during major surgery. It is a dilemma since nurses are being encouraged and, in some instances, ordered by physicians to perform these functions which the nurses believe are completely outside the scope of nursing practice, and for which they have had no sound preparation. At the same time they are being prevented from performing functions such as PAP smears, breast exams, and pelvic exams for which they <u>are</u> prepared.

This dilemma causes anger and frustration among nurses and in Ohio has had an affect on the job security of nurses. One has to wonder if there are really two issues, or more, involved in determing in the scope of practice. In the hospital setting, nurses are being pushed to perform outside the legal scope of nursing practice, yet in the community, they are being prevented from practicing clearly within the scope of nursing practice.

There has been a lot of healthy tension in our discussions. The task force recognizes the role economics plays in the whole issue, and acknowledges the fact that the number of physicians is increasing at the same time the level of preparation of nurses is increasing. Due to this fact, we believe tension will continue to increase.

The physicians and nurses in this task force believe each profession has the right to define its own scope of practice. The best care can be provided when, on entry into the health care system, the public has access to both nursing assessment and medical assessment--the best of both worlds. We have yet to arrive at a consensus statement that describes and defines this accessibility.

The Physician's Perspective:

Claire Wolfe, MD:

The traditional liaison of physician and nurse has, in recent years, come into jeopardy. Nurses might say this is because of the reluctance of physicians to adapt to changing times and practice patterns, the changing role of nurses in a rapidly changing environment. Physicians might say this is because of the aggressiveness of better eduated nurses who really want to practice medicine without going to medical school. Who determines the practice and scope of medicine? Who determines the practice and scope of nursing? Who determines when one intrudes on the other?

These questions, among others, form the framework for our Task Force, a Task Force created by the lawsuit by the Ohio State Medical Board against Health One and its nurse, and by the concern that introduction of the revised Nurse Practice Act at the next legislative session might engender a battle between two professions that should be working together rather than bloodying the other's nose with derogatory remarks.

With regard to the Medical Board/Health One affair, let me say that performance of breast exams and Pap smears were not the key issues, although they garnered the most publicity precisely because they are procedures that could indeed fall within the province of nursing. Also at issue was the unsupervised writing of prescriptions by the nurse, and the performance of the bimanual pelvic exam, a procedure felt difficult to do and interpret even by experienced gynecologists. But we are not here today to debate these points; that is one of the charges of the task force. This panel is to discuss the baseline attitudes of the participants and their perceptions of each other's roles.

What is the physicians' major concern with the current thrust of nursing's planned changes? Is he worried about his "turf?" his income? his "superiority?" his "deification" status? The latter delusion of physician infallibility has been well taken care of by a hungry press and an enlightened, better educated public.

Superiority? Physicians' egos may well be a big part of the problem and may account for some "knee-jerk" reactions to current events.

I doubt that concern over income plays a significant part in the physician attitudes toward nursing. Most physicians would not feel financially threatened by more active nursing roles.

What about the "turf" battle? It is here, in the realm of definitions and perceptions, where barriers begin. Most physicians still view the nurse as handmaiden, under their supervision. I think it is safe to say that most nurses do NOT view themselves as such. Even in physicians' offices with nurses who essentially "run the show," it is probably the rare exception that equality between physician and nurse exists in patient care decisions. When nurses begin talking about "assessment," "evaluation," "nursing diagnosis," and "independent practice," physicians perceive encroachment upon their "turf." Is this ego? antiquated tradition? or could there be a genuine concern for the patient's health?

Equality is a desirable goal, especially with a well educated nurse. But, when decisions must be made, especially in acute situations, someone needs to assume leadership, someone needs to captain the team. In the care of the patient, physicians feel that they have the training, expertise and the responsibility--moral, legal, and medical--to assume this role. Nurse may not argue with this role assumption in the acute situation. However, they may argue that a well trained nurse could assume this role in well care circumstances. Herein lies another basic conflict: who decides when "well care" becomes diagnostic screening? Who makes the entry level decisions? Do all patients need a physician? Or can some deal only with an independently practicing nurse?

The dilution of entry level care is a grave concern of physicians, and it is a concern born not out of the pocketbook, not out of the ego, but truly out of concern for the patient. We are talking about all the other allied health professionals who want a piece of that consumer and the health care pie. We are talking about chiropractors, who want to increase the scope of their practice-who want to be called physicians, who want to be able to alter the orders if they don't agree with the physicians, based on the training they receive in their expanded curricula; we are talking about the pharmacists, who want to be able to substitute other drugs from those prescribed by the physician if the pharmacist thinks the actions would be similar, even if the drug is not generically the same as that prescribed; we are talking about the physical therapists who want to evaluate and treat without referral or prescription by a physician; we are talking about nutritionists, mechanotherapists, naturopaths, PA's, and a whole host of others.

It is this assault by the droves that upsets physicians. Who will look out for the consumer? Who will be the patient's advocate? It's fine to say that a well-educated nurse can do just as good a job at this as a physician, but, by tradition and by training, this has historically been the physician's job. It may be argued that some physicians are less than optimal, but all physicians must fulfill a very specific educational program that spans at least ten years and often more. Although you are gradually upgrading nursing standards and nursing education, the vast majority of nurses currently in practice are NOT college-trained, and changes in the scope of nursing practice would apply to them as well as to baccalaureate nurses. Although it's been mentioned that the nurses would educate

the public about the qualifications of nurses, that is easier said than done. Even now, the great majority of people cannot differentiate between various "doctors"; an M.D. vs. a D.O. vs. a chiropractor vs. a podiatrist; an optometrist vs. an ophthalmologist; a psychologist vs. a psychiatrist.

And so we have our Task Force, with our tasks truly cut out for us, to try to resolve some of these issues, to try to understand each other and come to an understanding with each other, before we assault each other in a legislative arena. Both groups can gain very little from such a confrontation; they will both be bloodied. But, even more sadly, the two professions which should be working jointly for the best health of the public may develop an enmity that might rend then so far apart that the wound might never heal. We do not want that to happen!

Mary M. Janata:

You have heard a statement of some of the issues with which the task force is now dealing. As the chair, I want to remain neutral on the issues. The fact that I am an ordained minister may serve some useful purpose in the deliberations between these two professions. I do, however, have as my primary occupational goal a very much alive program at Ohio State University which I will address later.

The commission on inter-professional education and practice involves both the professional colleges and the professional associations of the State of Ohio. Of 18 inservice professions in a collaborative program, both nursing and medicine are involved in that effort, so I am very much interested in what happens around our table. I want to reiterate the purpose of the task force. We remark on the process of the work of the task force and underscore the importance of collaboration among the professions in today's society. Our purpose is to bring these two long-established honored professions together, with the patients' interest and welfare as the primary focus.

There is dynamism within each of the professions. Both medicine and nursing have developed capacities that they have never had before. From the public perspective, it is unseemly for these two old friends to go to court and do battle. This task force, under the Ohio Department of Health, was offered as an arbitrator providing a more professional avenue for these two groups to settle their differences constructively rather than destructively. Our purpose is to promote a collaborative relationship between medicine and nursing. Not only will the individual patients receive better health care from collaborative practice, but the corporate patient, which is society itself, will continue to trust these key professions as they have in the past without resorting to the courts or to governmental over-regulations.

Our process has important elements. One is that it is a small task force. The other is that it is a representative task force, as has been described, involving three important areas of both professions: the professional associations, the professional boards, and professional educa-

tion. The Ohio Board of Health offers a voluntary arena for discussion. It has the potential of affecting a broad range of concern in nursing and medicine, negotiating differences, and arriving at a broadly-based consensus.

The process that happens at the table is of great interest to me, as a neutral observer. No pre-conceived agenda has been brought to the table, nor pre-conceived outcomes. The agenda is generated by the group. The issues are identified through the discussion itself. There is, to my delight, full discussion of the issues with no holds barred.

We have attempted to sort out the areas of agreement and disagreement, and work through the areas of disagreement to whatever consensus is possible, with the willingness to agree and to disagree where consensus is not possible. I have observed the frankness of the constituents involved, their full engagement, and the tension, which is present for all members, in representing their professional constituencies and honestly hearing the perspectives of the other professions without falling into the deadly trap of either cheap grace, on the one hand, or cheap condemnation on the other.

So far as outcomes are concerned, as chair I am committed to neutrality on the content of the issues, and that content will evolve with the process itself, which is still incomplete. But I do believe that we see several procedural outcomes that are of extreme importance. Our work will eventuate in a document which will be submitted for approval to the constituent bodies. The document will, in some form, provide fundamental guidelines for collaboration between medicine and nursing in the interest of better care for the patient, and it will also address itself to the specific issues in current practice raised in our deliberations. It will also suggest an ongoing representative structure, not this task force, but one similar in make-up that will continue to deal with the emerging issues as they arise and with prevention of problems that can be foreseen before they arise. This, we hope, will encourage a climate for cooperation and collaboration among the professions.

The outcome will also have a great deal to say about education, not only within each profession, but among the professions. Inter-professional education at both professional school level and the continuing education level. The social climate in which the professions practice now is marked by extremely rapid social change. Advanced technology has raised ethical issues that are beyond the competency of any one profession to resolve. Changes in social values have produced epidemics of problems never seen before including chemical dependency, community and domestic violence, changing family structures, and problems of the aging. These are complex inter-related problems and they need comprehensive solutions. They are seen by professions as concrete cases, but we perceive them as changing social characteristics. At the same time, when these problems need to be examined comprehensively, we are seeing the greatest fragmentation of increasing specialization within the professions and isolation among the professions due to an explosion of knowledge.

Professional education needs to rise to the challenge of how to educate students to see the whole problem, to see their professional contributions and their limitations, to be conversant with the abilities of other professions who could contribute to the solution of the case and to be willing to adopt new modes of practice that use collaborative approaches in addressing problems comprehensively. New attitudes and working relationships between and among the professions begin with innovations in professional education. Now, that is the problem. I am devoted at Ohio State University to one model for a solution.

Tom Lant:

We have heard our panelists talk about the problems that they have faced and some of the approaches they are taking in Ohio to address them. I want to review some of their key thoughts with you. There has been some agreement in complimentary spheres of practice, in primary practice, and in the model of wellness care; however, we continue to have conflict in relationship to our respective roles on behalf of persons entering the health care system, due to our vocabularies, turf battles, income, egos, and the significant challenges of other allied health groups. In regard to allied health, as nurses, have we not contributed to that fragmentation by giving away nursing practice to other allied health groups such as dieticians, respiratory therapists, occupational therapists, etc?

We must face the attitude and value issues that undermine our profession. Mens' roles, womens' roles, aging, sexism, the changing family structure, and changes in our religious value systems. We also must evaluate what we have done to promote a uniform system of nursing education so that the physician and the consumer will be able to identify what our educational practice base is and what we are capable and competent of doing.

As primary practitioners in this country, we must not lose sight of the fact that our role as professional nurses is not to get into turf battles, but rather to promote health and wellness for our clients. We must also play our roles in preventing professional isolation. Both professions, nurses and physicians, face major crises today. If we think the nursing profession has problems, take a look at the medical profession. If they think they have problems, they should take a good look at us. But, together, we must continue to focus on the quality of nursing care which this country has come to expect of us.

Resolve Through Sharing:
A Comprehensive Program for Grieving Families

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When a family loses a baby through miscarriage, stillbirth, or newborn death, its members must adjust to the idea that they will live the rest of their lives without that child. The suddenness and unexpected nature of the loss may place the family in crisis with few resources available to help them cope. Childbearing families, for the most part, are inexperienced with death, planning funerals, and saying final goodbyes to a loved one.

This situation, coupled with the mother's early discharge from the hospital can leave these families filled with anguish over the tragedy for the rest of their lives. In the past, many nurses felt helpless, not knowing what to do or what to say to their patient. LaCrosse Lutheran Hospital and Gundersen Clinic recognized that a consistent manner of providing continuity of nursing care, both in the hospital and after discharge, was needed. The "Resolve Through Sharing" program was initiated in 1981 to meet that need.

All families who lose a baby at LaCrosse Lutheran Hospital/Gundersen Clinic have a "Resolve Through Sharing" counselor available to them. As a member of a interdisciplinary team, the counselor gives anticipatory guidance, empathetic support, information, and options to families. The role of the counselor is to involve the family actively in making decisions, and to coordinate care within the multidisciplinary team and ancillary services. Parents also have a parents' support group available to them which meets monthly.

The model for the one-to-one relationship is based on the nursing practice of two nurse practitioners specializing in high risk maternity care, Carolyn Smiley and Kathryn Hill-Goettl. The Planning Committee, which originally intended only to start a Parent Support Group, went on to design a program which included the one-to-one helping relationship as a core component.

All members of the multidisciplinary team attended an intensive certification program designed to increase their skills in helping grieving families. The following quote from a grieving parent was taken from a program evaluation form. It shows the kind of interaction provided by the counselors:

> "Our counselor was so helpful, we could not have made a lot of decisions without her. Knowing what grieving parents go through gave us an idea of what we could expect in the future as far as coming home, what people will say, etc. The books she gave us to read were also

helpful. It is nice to have someone with a medical background that could answer some of our questions, sometimes before we had to ask them!"

The goal of the one-to-one relationship is to help families cope with their grief in a positive way. "Resolve Through Sharing" staff is primarily made up of RN's and LPN's, and a few social workers. Counselors practice on evey unit where losses occur including Trauma and Emergency Center, Same Day Surgery, OB, Neonatal Intensive Care, Gynecology, and the OB/GYN Clinic. Currently there are forty-two counselors throughout the hospital and clinic.

Becoming a Resolve Through Sharing counselor involves three steps: 1) application; 2) interviews; 3) and successful completion of a 24-hour certification program. The certification course assists the counselor with communication skills; establishes a theoretical framework for care within existing policies, procedures, and protocols; and most importantly, helps them 'hear' the bereaved families and understand what their needs are. The certification course is for all multidisciplinary staff who work with grieving families (medicine, pastoral care, nursing, social services), though the content is geared specifically toward development of the counselor's role. The program is evaluated on a yearly basis.

STRENGTHS

Consistent Care of Grieving Families

Several things have influenced the continuity of care of grieving families, but the most essential is having the same counselor to provide support at the time of the loss and in follow-up after discharge. As one mother said, "My loss was a terrible shock to me - and I personally feel that of all the people I know, my counselor and my doctor were, and still are, the most instrumental people in helping me accept, cope, and grieve." The counselors are able to provide consistent care because of the thoroughness of the certification program and the established protocol for each type of loss. Counselors are "on-call" in all areas where losses occur, and in addition hold monthly meetings to share progress and build their expertise.

A Way of Communicating Concern and Interest

The one-to-one relationship between counselor and family allows the family to be recognized as special and deserving of the counselor's care. The "Resolve Through Sharing" counselor acknowledges the family's grief as unique, and is educated to understand that grief responses following the loss of a baby may vary from one family to another. Counselors provide written material to families and serve as a resource person for the extended family. Another quote from a spouse provides an example:

"As a father and husband, I strongly appreciated being treated as part of the family. The trauma at first seems only to involve mother and baby, but I experienced your staff's awareness that we needed to be kept together and treated as a family."

Improved Discharge Teaching and Planning/Follow-up

Follow-up contacts with families after discharge follow an established protocol specific to this program. Essential elements include phone calls at specific intervals and a grief conference involving the family, counselor, obstetrician, and/or pediatrician, and any others the family desires at approximately six weeks after the loss. Also an invitation is extended to the family to attend the Parent Support Group and information is provided about other resources that might be helpful to them.

The greatest need for counseling is after discharge, since it is usually not until after the families return home that the loss becomes a reality and the shock and numbness subside. Families consistently express their appreciation for the contact after discharge and the grief conference which, for many families, significantly influences their healing process, as expresed in the following quote:

"Keep up the good work!! Your phone calls helped me tremendously. I was amazed at how much you cared. I think talking about my miscarriage really helped me accept our loss."

Personal Growth of Counselors

Counselors express that following certification they are better able to accept many types of behavior and attitudes that they see in people. They also find that the concept of grief applies to many other areas of life. Besides enhancing their knowledge base and improving care for all patients, the counselors are very supportive of one another. Through monthly meetings and retreats, they get to know each other well and come to rely on each other's advice in making professional decisions. The following is a comment of a "Resolve Through Sharing" counselor in the Neonatal Intensive Care Unit:

"But because of 'Resolve Through Sharing', we are now trying to understand what death is all about and the very central part that it plays in life itself. We have been able to re-direct our focus and decide that, in fact, there is something major we can do for families experiencing death of a baby. Though we cannot make their infant survive, we can help them make the most out of this very devastating experience."

Personal Growth of Caretakers

"Resolve Through Sharing" has had an impact on all people caring for grieving families. Primarily these changes have occurred in the following

areas: 1) more constructive attitudes toward grieving families; 2) increased sensitivity to people's problems in general; and 3) a better understanding of grief after miscarriage. A physician said this about the program:

> "Prior to my involvement with the 'Resolve Through Sharing' program my dealings with bereaved parents were of a superficial nature. I did not appreciate the depth of their emotions and did not realize how important my words and actions were in their lives. The lessons I have learned because of 'Resolve Through Sharing' have affected my entire medical practice in a very positive way."

Other departments were also affected by the program, especially the laboratory where requests are made for the preparation of the baby or tissue for the parents. From the Lab Supervisor we received this statement:

> "At first when counselors started asking for things, we thought it was a lot of trouble. We had been trained to be scientific in our approach. Now we are so glad to be involved in this humanistic process. We really care about these parents - it is something we can do personally for them."

Suggestions for a Quality Program

The support of our hospital administration has been vital to the implementation and on-going performance of "Resolve Through Sharing." Hospital and nursing administration were both represented on the "Resolve Through Sharing" Planning Committee. In addition, quality is ensured through on-going evaluation of the counselors, Parent Support Group, and the certification program. We also feel that an interdisciplinary approach to planning and implementation provides a more comprehensive way of meeting the needs of grieving families. We also plan to have a clinical psychologist or psychiatrist to provide on-going consultation.

Collaboration between Nursing Education and Service
A Pro-Active Decision Making Model

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Introduction

Between 1981 and 1984 Miami Valley Hospital and Wright State University in Dayton, Ohio planned for the development of a collaborative nursing model between education and service. (Figure 1) This paper will:

1) summarize the development of a collaborative model between a school of nursing and a division of nursing service;

2) identify ways in which the collaboration process has and will enhance a practice environment for decision making regarding both patient care and nursing education;

3) share the planned collaboration model and the organizational structure of the two organizations; and

4) present the agenda for ongoing planning of the collaborative nursing model at Wright State University - Miami Valley School of Nursing.

Nurses involved in the planning process have felt responsibility and accountability for decisions in the development of the collaboration model. The formal structure of the model will assure ongoing pro-active decision-making for nursing.

Development of the collaboration model

Change evolves in response to both internal and external forces in any system. Peters and Waterman, in their book In Search of Excellence (1982) indicate that successful companies are constantly responsive to the environment. In this situation, the leadership at Miami Valley Hospital reviewed the hopsital's involvement in and support of nursing education. The current diploma program was studied in relation to the health care system, its overall contribution to nursing and its cost. The hospital wished to remain active in nursing education and establish a Center for Nursing Excellence consistent with the Miami Valley Hospital mission. Several educational alternatives were considered; the School of Nursing at Wright State University was approached.

Figure 1

COLLABORATION BETWEEN NURSING EDUCATION
AND SERVICE - A PRO-ACTIVE DECISION-MAKING MODEL

A steering committee was established to begin negotiations; membership included administrators from both Wright State and Miami Valley, with nursing a majority of the membership. The committee's purposes were to:

1) develop a philosophy and goals of a collaborative program;

2) propose a curriculum consistent with collaboration;

3) establish resource requirements;

4) develop a plan for sharing resources and fiscal responsibilities;

5) develop an implementation schedule for phase-in of the collaborative program;

6) develop a marketing and promotional program; and

7) monitor program implementation.

All of these purposes were explored with the intent of determining whether the collaboration between the two institutions would be feasible and acceptable to both parties. A contractual agreement did not exist in this period of exploration.

During this phase, nursing's primary responsibility was for determining and examining the issues. The process included:

1) meeting of a nursing administrators' subcommittee;

2) exploration of the collaboration/unification process as practiced in other institutions;

3) defining the goals of collaboration;

4) involving faculty and staff of both institutions;

5) clarifying the interaction as one between the School of Nursing at Wright State University and the Division of Nursing of Miami Valley Hospital (it was not intended to be a merger between a diploma and a baccalaureate program); and

6) recognizing the process as a new venture; assuming and accepting the responsibility of educating, informing, and interpreting the issues of a potential collaboration to the top administrators and Board of Trustees of both institutions.

The nursing leadership provided the directions for each institution in determining the terms of the contractual agreement and preparing the reports for the Boards of Trustees in order for them to make the final institutional decisions. Important also was the identification of <u>why</u> a collaborative model should be developed. Since both institutions could

exist alone, the discussion of the collaborative model vs. a traditional affiliation agreement was necessary.

Collaboration Process: Decision Making in the Nursing Practice Environment

The process of developing the model has been extensive. It has required a lot of give and take, a lot of introspection on the part of those both in practice and education. We do, however believe that positive, structured collaboration between service and education can greatly enhance the education of our future professional nurses; and concurrently and ultimately it can enhance the delivery of nursing care.

A formal collaborative system can provide:

1) buffering from future uncertainties in health care delivery and health professional education (regulatory changes, DRG's, decreased number of clients);

2) decrease of each institution's dependence on external elements such as access to well prepared nursing graduates and access to quality clinical sites for nursing education;

3) assurance of quality of nursing practice;

4) strength for the professional environment and pro-active decision making;

5) increase of the accountability between nursing service and nursing education.

The intent of this model will be to focus on quality nursing practice for society.

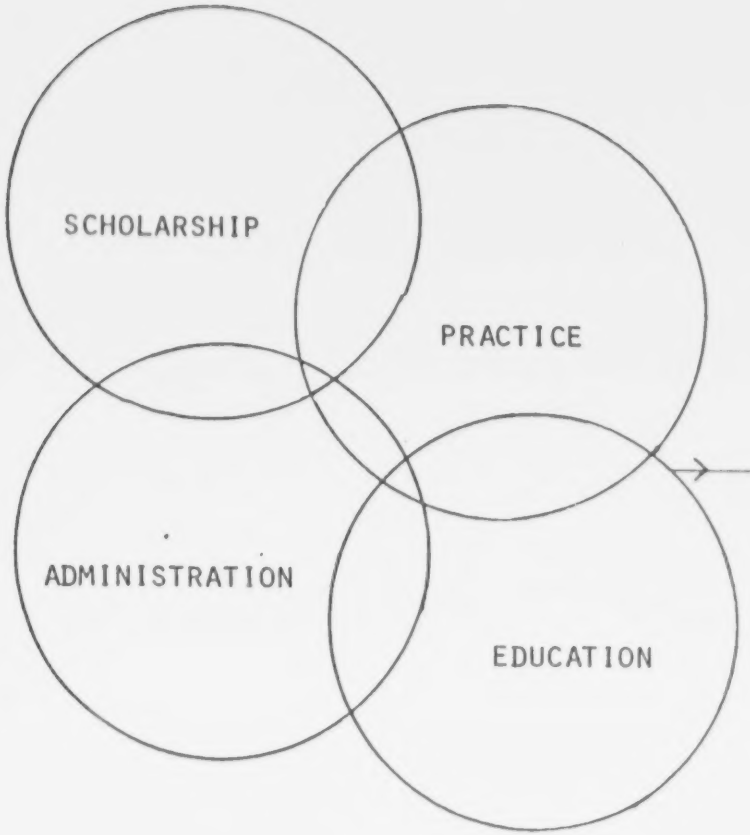
Figure 2 outlines the cooperative aim of nursing scholarship, practice, administration, and education toward achieving three outcomes related to quality nursing practice.

Collaboration Model: Organizational Structure

The development of an organizational structure conducive to these goals was not an easy task. At this time the administrative or governing portion of the system is now developed; further work will continue to develop the model at the education-practice and faculty-staff level. There were a number of questions which were asked in the development of the structure including:

1) What committees and committee memberships would be necessary to identify and implement the collaborative process?

Figure 2



PRO-ACTIVE DECISION-MAKING →

1. DEVELOPMENT OF NURSING KNOWLEDGE.
2. ENHANCEMENT OF QUALITY HEALTH CARE.
3. ASSURANCE OF PROFESSIONAL COMPETENCE.

2) What kind of structure would facilitate the collaboration but at the same time preserve the accountability, autonomy, and integrity of the separate missions of each institution?

3) What resources would be basic to a collaborative model; how would the resources be shared?

4) What would provide optimum socialization and participation for nurses at each level of each system?

5) What would best access and use the knowledge and expertise of individuals in each institution?

6) What would be ways to enhance decision-making and communication between the two institutions?

7) How would we provide for an evolving structure that stimulates creativity, entrepreneurship, and responsiveness to the environment?

8) How do we resolve conflict and disagreements?

The collaborative program governance structure has been identified and is confirmed by contractual agreement. It is diagrammed in Figure 3.

Joint Executive Committee Responsibilities

The responsibilities of the joint executive committee are:

1. policy formulation relating to financial, legal and general program matters; and

2. formulation of long-term plans related to the collaborative program.

Joint Coordinating Committee Responsibilities

The responsibilities of the joint coordinating committee were:

1) provide for ongoing planning, implementation and evaluation of the collaborative structure;

2) decision-making regarding employment, responsibilities, and evaluation of joint appointees; and

3) identification and allocation regarding the sharing of resources.

Planning Agenda

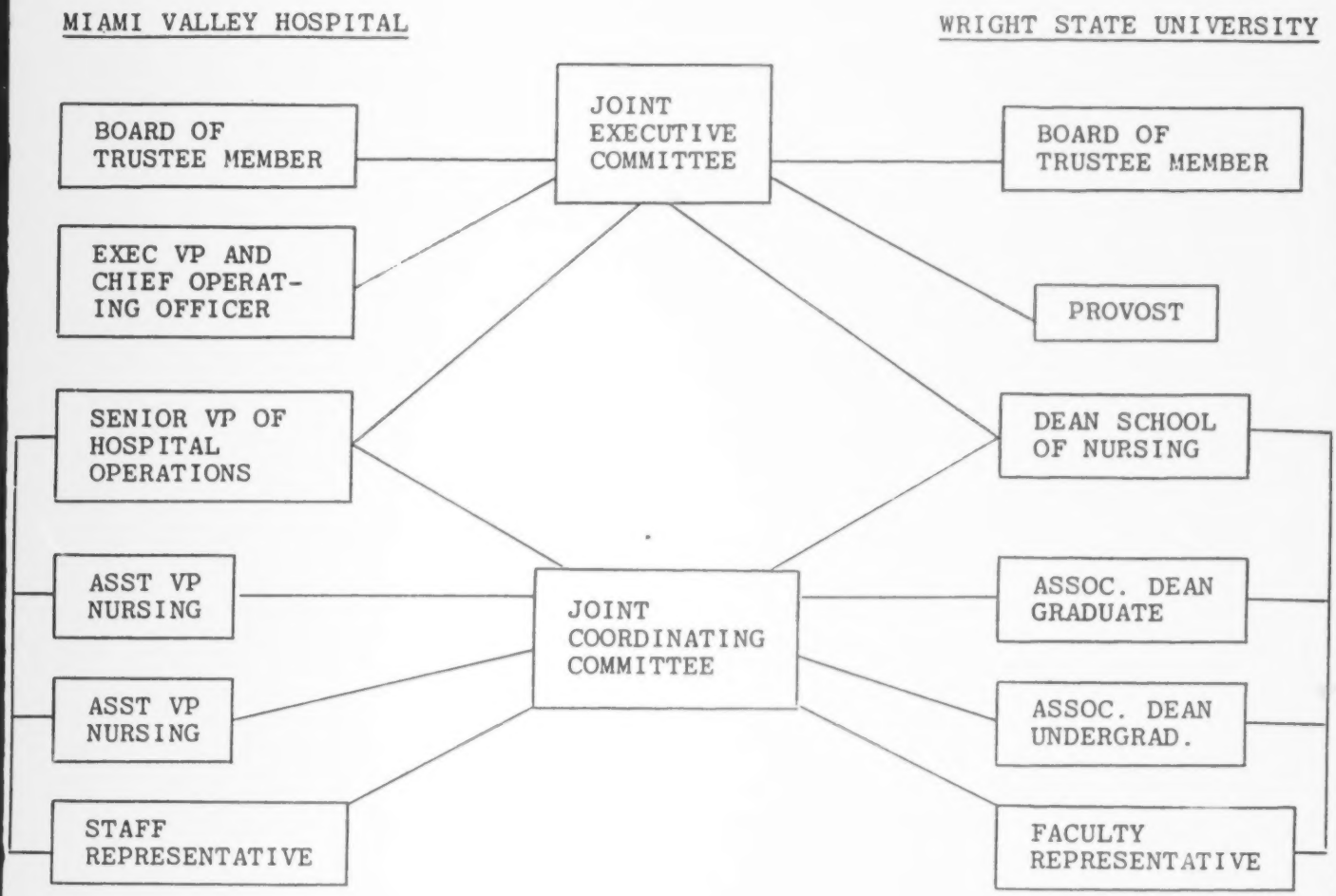
The contractual agreement was completed in May/June 1984. This coming year will be more or less a phase-in or beginning implementation

Figure 3

WRIGHT STATE UNIVERSITY-MIAMI VALLEY

SCHOOL OF NURSING

GOVERNANCE
COLLABORATIVE PROGRAM



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year. We feel that a high level of involvement and emphasis during this first year will be crucial to the ongoing success of the program.

Several of the agenda items include:

1) further development of a structure that allows for flexibility, creativity, and ambiguity;

2) formative and summative program evaluation;

3) establishment of a Center for Nursing Excellence;

4) socialization for collaboration; and

5) marketing and public relations.

Summary

The process stages we followed in reaching collaboration are similar to those identified by Styles (1984). Styles' model is reflected in Figures 4 and 5. The degree to which nurses are involved in each stage of the planning will determine how pro-active they will be.

Figure 4

STAGES OR DEGREES OF UNITY

STYLES, 1984

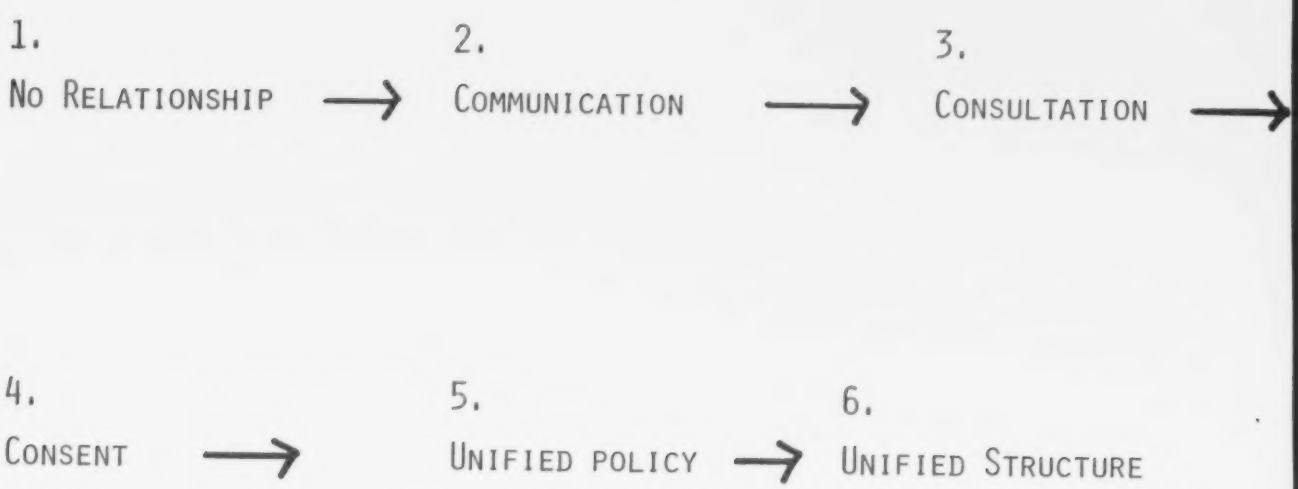
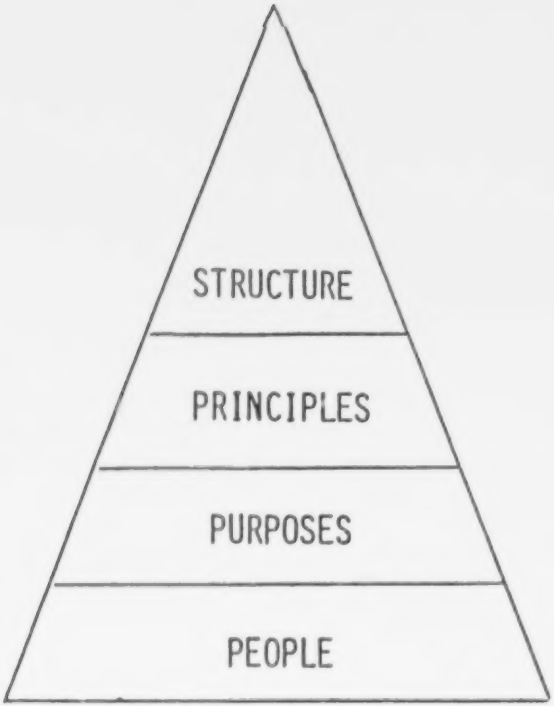


Figure 5



HIERARCHY OF ELEMENTS IN COLLABORATION

STYLES, 1984

REFERENCES

Lindeman, C.A. Nursing education perspective on the changing health care payment system. Presentation at Nurse Executive Briefing, Division of Nursing, American Hospital Association, Chicago, Illinois, September 26, 1983.

Peters, T. and Waterman, R. In Search of Excellence. New York: Harper and Row Publishers, 1982.

Skortel, S. and Kaluzmy, A. Health Care Management. New York: John Wiley and Sons, 1984. p. 156.

Styles, M. M. Reflections on collaboration and unification. Image, Winter, 1984, 16, (1); pp. 21-23.

Werner, June. Nursing practice perspective on the changing health care payment system. Presentation at Nurse Executive Briefing, Division of Nursing, American Hospital Association, Chicago, Illinois, September 26, 1983.

Problem-Solving Management in a Pro-active Environment: Developing Therapeutic Interventions for Children of Domestic Violence

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There is no place as violent as the home. When it comes to private violence, it is impossible to ascertain the numbers of women and children living in violent homes. Estimates indicate that from two hundred thousand to six million women are physically abused every year. From 1982 to 1983, the Family Center in Springfield, Missouri sheltered 122 women and their 164 children. These children were deeply affected by this violence, either through witnessing it or by being the actual recipient of the violence. According to national statistics, 40 to 66 percent of these children were physically abused themselves.

Not only is domestic violence an extremely complex problem it "perpetuates itself, reproducing, like a poisonous plant, sending out spores." (Anderson, 1983) Family violence is intergenerational in nature. Children from violent homes become more tolerant of violent behavior and see this as a norm.

Very little information or literature has been written concerning interventions used with children living in violent families. Planning direct interventions for these children, specifically those in shelters, is a relatively new phenomenon. Several children's programs have just been started within the past few years in the United States.

Children from violent families present a multitude of problems. These include: physical, mental, social, psychological, and developmental dimensions. Gifford (1983) believes there are many practical ways to help the children. She says:

> "Everyone in the family--the abusing father, the battered wife, the onlooking child--is a victim. But, the ones with the greatest potential for help are the children. (p. 14)"

Helping these children is a community health nursing problem of epidemic proportions. Because decision-making and problem-solving are integral parts of nursing practice, nurses must use systematic approaches to solve complex problems of this type. Planned change strategies were used as the basis for the design, implementation, and evaluation of the nursing

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***This paper is a summary of a project done during Spring 1984 at the Family Center, Springfield, Missouri. The project involved nurses as leaders and change agents.**

FORCE FIELD ANALYSIS

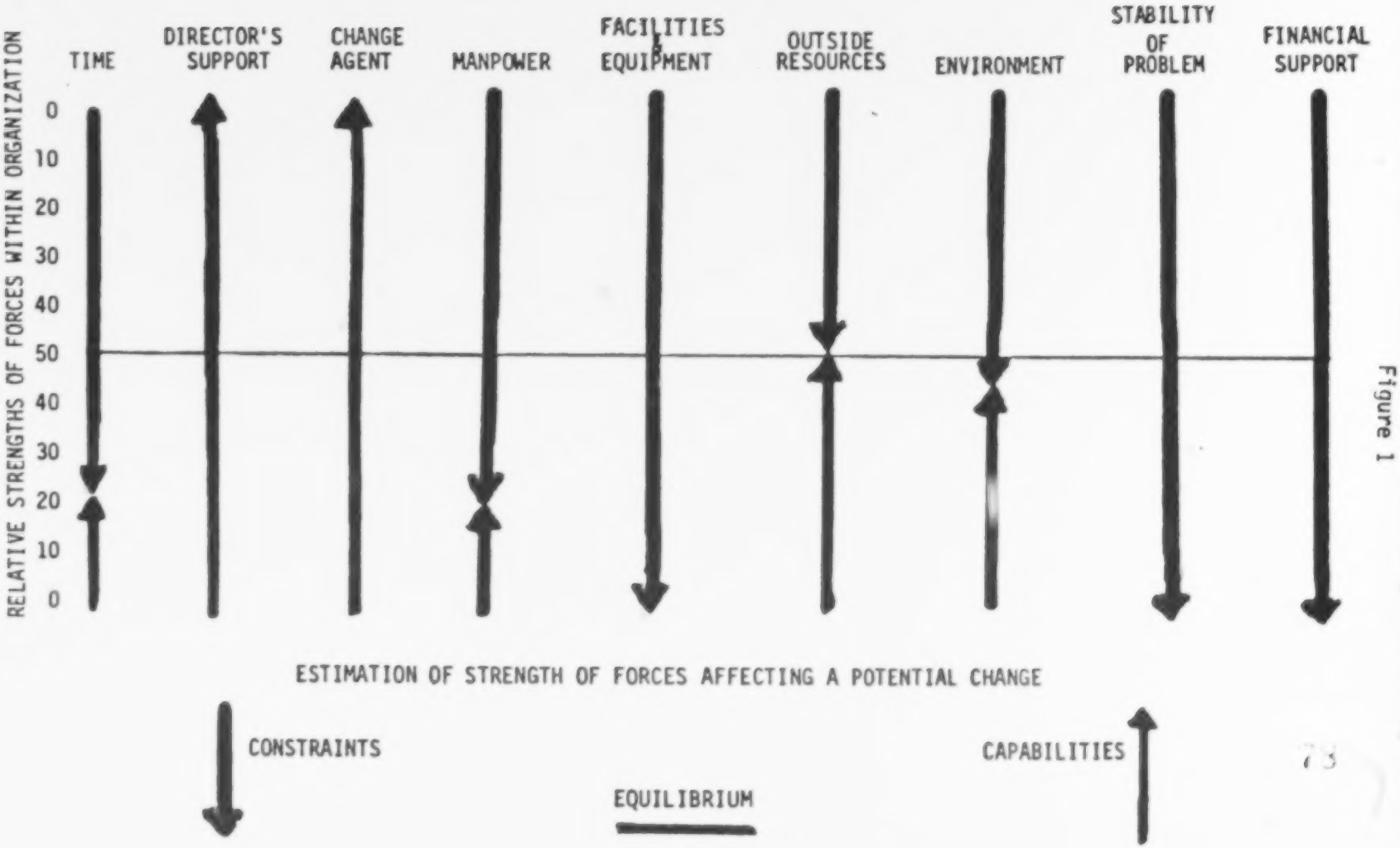

Figure 1

systems developed to provide therapeutic interventions for the children from violent families who came to the Family Center. The particular change strategy used was based on seven steps:

1) clarifying the problem;

2) analyzing the situation;

3) designing the conceptual framework;

4) generating solutions;

5) implementing;

6) evaluating; and

7) making recommendations. (Bailey and Claus, 1975)

Step One: Clarifying the Problem

The need for change was assessed through a literature review, interviews with battered women and their children, and the need as perceived by professionals at the shelter.

PROBLEM STATEMENT:

The Family Center sheltered women and their children who found it necessary to escape their violent family situation, and only indirectly helped the children by working with the mother. From November 1982 through November 1983, 122 women used the Family Center. One hundred sixty four children came to the shelter with their mothers. These children stayed at the shelter for time periods lasting from a few hours to two weeks. At first there were no planned direct interventions with these children of violent families. Only later was it recognized that it is essential to meet these children's needs if we are to alter the intergenerational 'contamination' of children by violence of adults.

After the problem was stated, the purpose, goals, and objectives to resolve the problem were specified.

PURPOSE:

Attempt to meet the children's needs while at the Family Center.

GOALS:

1) Provide intervention directly to the children.

2) Help break the cycle of intergenerational violence.

OBJECTIVES:

1) Gain the children's trust.

2) Teach children that family violence is not normal.

3) Teach children that violence is unacceptable.

4) Show children empathy.

5) Give the children physical, emotional and mental support.

6) Initiate a positive approach to discipline through love and concern.

7) Give each child unconditional positive regard.

8) Assist the children in having a positive image toward men.

9) Teach children to respect other people.

10) Provide a climate of structure and routine.

11) Reinforce a feeling of safety and security.

12) Establish stable relationships with role models.

13) Decrease feelings of isolation, frustration, confusion, and guilt.

14) Assist children in acquiring a positive self-image, self-respect, and self-worth.

15) Help children express and accept their feelings -- both positive and negative.

16) Create a nurturing environment.

Step Two: Analyzing the Situation

Once the problem was defined, the nurse, as change agent, weighed the constraints and capabilities in the situation. Since these forces were not static, they were agreeable to movement. The change agent capitalized on the positive forces and made the negative forces less resisting.

The nine forces analyzed in this situation were: time; director's support; change agent; manpower; facilities and equipment; outside resources; environment; stability of the problem; and financial support. The director's support and the nurse as change agent were the only two factors viewed as positive. Since the factor, "outside resources" appeared to be most agreeable to movement, it was the first factor to be

approached. Once "outside resources" became a postive force, all six negative forces became subtantially less resistant. (Refer to Figure 1)

Step Three: The Conceptual Framework for Problem Solving

The conceptual framework was merely a way of specifying an approach to solving the problem. Implementation interventions for the children would change the rules and internal order of the organizational structure and thus, change the system itself. Decision-making focused on a set of related objectives which were all considered critical. The problem was not viewed as an isolated event but as a series of interrelated events with varying stages of needs to be met. There were many considerations: selection of interventions to be used; the way they would be implemented; and who would facilitate the actual interventions. The problem was also defined as a closed-loop. This meant that once decisions were made they could be reversed without a great expenditure of resources. Feedback would allow for experimentation, adjustments, or any necessary changes.

Conceptual Framework using Orem's Theory of Nursing

The self-care deficit theory, set forth by Dorothea Orem, was used in developing the conceptual framework. Basically, Orem (1980) says that individuals are responsible for themselves -- for their own self-care. The ability for self-care and care of dependent family members (children) proceeds along a continuum and is proportional with respect to its components. As a woman's ability for self-care decreases so does her ability to care for her children. The functioning and development of her children becomes deficient in proportion of her inability to care for herself. According to Orem, the condition that validates the need for nursing with these children is "the inability of the parent to maintain continuously for the child the amount and quality of care that is therapeutic." (1980) The word therapeutic means everything from physical safety to the various levels of child development.

A nursing system is formed when a nurse diagnoses, prescribes, designs, and implements nursing actions. These actions or systems allow individuals to engage in self-care and meet their self-care requisites, therapeutically. Nursing systems formed for battered women and their children are compensatory, supportive, and educative.

Step Four: Generating Alternatives

The most efficient way to decide upon a solution was to design a decision matrix. Alternative solutions to resolve the problem were listed. The alternatives were: identify volunteer resources for the Center; hire a child advocate; use a model program from another shelter; initiate one component of the children's program (ie. basic crisis interventions); and form a steering committee.

The critical and non-critical objectives that the alternative was required to meet were then identified. The three critical objectives were: cost, meeting the child's needs, and acceptance by the Center's director. The noncritical objectives were: time, knowledge, and acceptance by the board of directors. Each alternative was weighed against these objectives on an ordinal scale designated as low, medium and high. The two decision rules were that the alternative must meet all the critical objectives and come closest to the ideal solution. In this situation, forming a steering committee to resolve the problem was chosen because it met all six of the objectives. Thus, the steering committee was the ideal solution for meeting the children's needs at the Family Center. (Refer to Figure 2)

Step Five: Implementing the Solution

Implementing involved the following major management functions: planning, organizing, directing and leading, and controlling. The function of the steering committee was to study the problem and to present strategies for resolution. Careful consideration was given in the selection of committee members. The nurse change agent needed to secure a commitment from individuals aware of community, regional, and national resources necessary for the program's success. The steering committee consisted of:

Deborah Wallace, RN, BSN -- Change Agent and Chairperson

Mary Ann Kimura, MS (Guidance and Counseling) - Executive Director of the Family Center

Frances Anderson, RN, MN, MS (Psychology) - Private Practice; Nursing Instructor, Southwest Missouri State University

Shirley Hendricks, PhD - Professor of Guidance and Counseling, Southwest Missouri State University; Elementary School Counselor

Mary Nau, MS (Guidance and Counseling) - Coordinator of Home Visitor Program, Springfield Missouri Health Department; Family Counselor, Division of Family Services

Christine Squibb, BS, MBA - Regional Coordinator of Missouri Youth Network; Family Center Board member; President, Child Advocary Council.

Each committee member received the nurse change agent's literature review, a copy of a model children's program from the Fayetteville, Arkansas shelter, and relevent statistics from the Family Center. The committee was so excited about resolving the problem, they requested to meet every two weeks unitl they had identified specific problem-solving strate-

Figure 2

DECISION MATRIX

Alternatives	Decision Performance Criteria						
	Critical			Non-critical			
	Cost	Meets Child's Needs	Acceptance by Director	Time	Knowledge	Acceptance by Board	Score
1. Identify volunteer resources for Center	Low	Low	Low	Low-Med.	High	Med.	3
2. Hire Child Advocate	High	High	High	Med.	High	Low	4
3. Use model program from another shelter	High	High	High	High	High	High	4
4. Initiate one component of program eg. crisis intervention	Low	Med. High	High	Med.	High	High	5
5. Steering Committee	Low	High	High	Med	High	High	6
Ideal	Low	High	High	Low-Med.	High	High	6

Decision Rules

1. Alternative must meet all the critical objectives.
2. Alternative must come closest to the ideal.

5.3

5.3

gies and made some definite plans. Over a three month period the following interventions were initiated:

1) Basic crisis interventions:

Children were viewed as individuals who were in a state of crisis with specific needs and not merely "Mrs. Smith's kids." They were made to feel welcome, safe, and important. Time-out was used as approach to discipline (no spanking or negative remarks).

2) Support therapies:

Graduate students in the Master's in Guidance and Counseling Program at Southwest Missouri State University conducted group and individual counseling sessions under the guidance of Shirley Hendricks, PhD. These were considered support therapies and they utilized art and play therapy, feelings and self-esteem activities. Group sessions were scheduled twice a week. Individual counseling was intitiated as each child's needs warranted it.

3) Positive role-modelling:

The Family Center staff (Director, Counselor, Resident Manager and Secretary) approached their daily activities as positive role models: teaching parenting skills to the mothers; showing appropriate behaviors in conflict resolution; and assisting communication between each mother and child.

4) Family therapy:

Frances Anderson, RN, MN, MS, Psychology, initiated the family therapy program. This program involves family assessments; helping the family understand crisis problems and crisis intervention, and making referrals to the city and county mental health programs and private counselors.

5) Assessment tool:

Mary Nau, MS, Guidance and Counseling has been working to develop an assessment tool for the children so that specific problems can be identified more consistently. Referral is then made to the appropriate professional agency to assist that particular child.

Step Six: Evaluating:

Being one of the most important elements of management and implementation, evaluation procedures provided the nurse change agent with a method for assessing decisions. As in the nursing process, formative evaluation was done informally throughout the process. This determined what progress was being made toward reaching the goals of the committee.

Because the nurse change agent is still involved in this change process, a formal summative evaluation has not been done.

Step Seven: Making Recommendations:

When the steering committee had begun to function effectively and strategies for resolving the problem were being implemented, the nurse change agent was able to terminate as the chairperson of the committee. Although the nurse will no longer be directing the change process, she will consult with the group and examine their progress periodically. At the time of termination the nurse change agent made recommendations for further adjustments in the change process and encouraged the Center staff to develop some of their own problem solving techniques more fully. For instance, two recommendations were:

1. Have the committee communicate their strategies and program developments to the Family Center Board of Directors, and

2. Continue to use the Arkansas Project for Victims of Domestic Violence as a model for designing the program for the children.

In summary, decision making and problem solving are integral parts of nursing practice. As nurses face the problems inherent in our present health care system and search for ways to assume their role as pro-active decision makers, they must use systematic approaches to problem solving. Pro-active professional nurses can use these planned change strategies to design, implement, and evaluate nursing systems to affect the resolution of client discrepancies in any environment. The authors believe that the pro-active involvement of a nurse change agent in this problem solving process has resulted in an improvement in the care provided for these children. The authors were able to show the need for nursing in this environment, and ultimately to affect decisions in this challenging community health problem.

REFERENCES

Anderson, K. Private violence, Time, September 5, 1983.

Bailey, T. and Claus, E. Decision Making in Nursing: Tools for Change, St. Louis: C.V. Mosby, 1975.

Gifford, L. Family violence shelters: How they can help children. Texas Child Care Quarterly, Spring, 1983.

Hughes, et al. Training Manual for a Children's Program in a Shelter, Project for Victims of Family Violence Grant #90-CA875/01. P.O. Box 2915, Fayetteville, Arkansas, 72702.

Orem, D.E. Nursing: Concepts of Practice, 2nd ed., New York: McGraw-Hill Book Company, 1980.

An Assessment of Nursing Care Activities in Ambulatory Settings

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Overview:

The changes in the overall health care environment are expected to have a profound impact on ambulatory care:

* Technologically complex procedures which once required hospitalization will be performed on an outpatient basis.

* With earlier discharges, the ambulatory patient will be seen sooner after discharge from the hospital, and more frequently during the post-hospital recovery phase. As a result, the relative acuity level of the patients seen will increase.

* The patient education process will increasingly shift to the ambulatory arena. This will occur for several reasons: 1) the acuity level of patients at discharge from the hospital will not be conducive to learning; 2) consistent with trying to minimize hospitalizations, the role and effectiveness of ambulatory patient education will become more important; and 3) the educational preparation for surgical hospitalizations will be done prior to hospitalization so that the date of admission will become the day of surgery.

Consequently, the total patient volume and complexity of care in ambulatory services will increase. With these increased demands, the roles of the providers of ambulatory care will come under increasing scrutiny. Part of that scrutiny will appropriately include the costs of providing care; and we are all aware of the importance of costs in the process of negotiating resources.

When one looks at the staffing of ambulatory care centers one quickly notes the range of nursing preparation used. There are centers where the care is provided by medical assistants who have been taught skills through on-the-job training or in short, technical programs. At the other end of the education continuum, care is provided by master's prepared clinical nurse specialists. The most common pattern seems to be a mixture of educational backgrounds with RN's, LPN's, and medical assistants.

Athough there are a few articles in the literature where the staffing of particular ambulatory care centers is given, there are no patient acuity or work-load index methods to plan ambulatory staffing. The staffing usually is the result of the negotiating skill of the nurse administrator, physician director, and/or clinic administrator.

Project Background:

The site of the initial project was Henry Ford Hospital, Detroit, Michigan. The Ford system includes a main campus located in Detroit which contains the hospital, a 17-story clinic building and other education, research and office buildings, and suburban clinic satellites. The annual outpatient volume for the system exceeds one million patient visits.

At the beginning of this project I was the nursing supervisor for the main campus clinics and a student in a Master's Degree program in Business Administration. One of the first classes which I was scheduled to take was a statistics course. Having already completed a Master's in Nursing with the usual statistics and research components, I was given the opportunity to do a directed study using techniques which were not part of my earlier coursework. I wish to acknowledge the contribution of Dr. Ronald L. Tracy, Assistant Professor in statistics at Oakland University, in the development of the statistical methodology and computer programming involved in this project.

Site Description:

In the Fall of 1982, Henry Ford Hospital was beginning to plan the physical merger and relocation of its six Internal Medicine Divisions. These clinics were located in various areas of the 17-story clinic building. Three of the clinics had medical sub-specialties of genetics, bone metabolism, and executive medicine (health check-ups for business executives). The clinics were generally staffed with LPN's and nursing assistants, though one clinic did have an RN. The daily patient volume of the clinics varied from 18 to 45. There were physical differences (some of the clinics drew blood in their area) and protocol differences (the tasks performed for physical exam and routine appointments differed between clinics).

Objective:

One of the issues for the consolidated clinic would, of course, be staffing. The objective of the study was to assess the current patient care activities of the nursing staff using multiple regression techniques. The results could then be a springboard to the discussions of the nursing care activities and staffing for the new clinic.

Instrument:

Group discussions were held with the head nurses to determine a format for capturing information about each patient care encounter. We decided that each visit could be thought of as having three discrete functions: a check-in function, an exam room function and a check-out function. The tasks performed for each of these functions were then identified. For each patient care encounter, a form would be completed. For each interaction with the patient, the staff would indicate the time that interaction began on the "Time In" line, the time the interaction ended on the "Time Out" line, the tasks performed during the interaction. The form was given four trials before the group was satisfied with the form design/

content and the consistency with which staff members used it.

Procedure:

A data sheet was completed on every patient seen in a clinic for a two-day period for a total of 449 patient visits. The head nurses selected the two data collection days for their clinic from a seven day period. Since nursing staff members frequently completed different tasks for any given patient, the nurses either kept the data collection sheets at the nurses' stations or clipped them to the patient's medical record.

Methodology:

Multiple regression is a multivariate analysis technique most useful for studying complex phenomena in which one dependent variable can be influenced by several independent variables. Our dependent variable was the time to complete a group of tasks and the independent variables were the tasks performed. The specific model which we employed was the binary regression model. In this model, the independent variables take on only the values 0 or 1. The model and an example would be the following:

$$y = a + b_1 X_1 + b_2 X_2$$

where

y is the time it takes to do a series of tasks
$X_1 = 1$ if the task of taking the pulse rate is performed
$X_1 = 0$ if not performed
$X_2 = 1$ if the task blood pressure is performed
$X_2 = 0$ if not performed

and a, b_1, b_2 are the regression weights given by the computer analysis such that

a = miscellaneous time to greet or converse with the patient
b_1 = the mean additional time to take the patient's pulse
b_2 = the mean additional time to take the patient's blood pressure

On a time line, these could be considered as:

	T I M E			
0	a	$a + b_1$	$a + b_2$	$a + b_1 + b_2$
	Greeting	Greeting & pulse	Greeting & BP	Greeting, pulse & BP

Therefore, the average time to complete any series of tasks can be determined by adding the times of each individual tasks and the greeting/ miscellaneous time.

The complete statistical results and times per task have been published in the Spring, 1984 issue of the Journal of Ambulatory Care Management.

Application of Results - Project Site:

1. The average amount of time for the functions were as follows:

Check-In	5.27 minutes
Exam Room	3.76 minutes
Check-Out	4.57 minutes
TOTAL AVERAGE NURSING TIME	13.60 minutes

2. The objectivity of the information can be most useful. For instance, in one clinic which drew their own blood samples there were three nursing assistants whose primary function was blood-drawing. As had been frequently noted by the nursing, medical, and administrative staffs, there were periods in which the personnel and space available for the blood drawing task appeared to be inadequate, and conversely periods in which the assistants were underutilized. Although 40% of the patients seen each day required blood to be drawn, the actual average amount of time utilized to meet the demand was only 3.15 hours per day. Eventually, the number of assistants was decreased to one. The issue of whether the consolidated clinics should be drawing blood was not addressed.

3. Comparisons could be made between the clinics on the amount of time required to complete activities. Although one can argue the quantity of time vs. the quality of time involved, it was most interesting to note that the clinic with the RN was consistently more efficient. This was also the clinic which was perceived as rendering the highest quality of care relative to the other clinics.

4. The teaching task was only significant in one clinic - the clinic with an RN.

5. Documentation by writing nursing notes was not statistically significant, even in the clinic with the RN. This was congruent with some of the quality assurance studies being conducted which demonstrated a need for more thorough nursing care documentation.

6. From the demographic information we were gathering, it was determined that age, sex, and mobility assistance did not significantly affect the nursing time required for any function.

Application of Results - Development of Protocols and Staffing

Although the data we obtained needs to be refined through replication, one can use the information to consider the impact of protocols and the number of staff needed to provide the care. For instance, in considering three situations of a clinic with 200 patient visits per day: what happens to the amount of nursing care required as the type of visit changes? Using the following protocols, if the physical exam check-in requires 10 minutes, and the routine office visit check-in requires 4 minutes, the change in the proportions of the types of visit has the following effect on the hours of nursing time needed for direct patient care:

PROTOCOLS

Physical Exam		Routine Office Visit	
Task	Minutes	Task	Minutes
Greetings	2.27	Greetings	2.27
Temperature	1.94	Temperature	1.94
Height	-.55	Weight	-.65
Weight	-.65	Blood Pressure	-1.23
Blood Pressure	-1.23	*Routine Visit	.55
Vision	2.02		
*Physical	6.18	TOTAL TIME	2.88
TOTAL TIME	9.98		

*Note: The "Physical" and "Routine Visit" categories represent average additional time spent on other miscellaneous tasks such as tonometry, or pulmograms, for each patient.

CHECK-IN PROTOCOLS: 200 PATIENTS PER DAY

Physical Exams	Routine Visits
N = 50	N = 150
Time = 500 minutes	Time = 600 minutes
TOTAL TIME = 18 HOURS, 20 MINUTES	
N = 100	N = 100
Time = 1000 minutes	Time = 400 minutes
TOTAL TIME = 23 HOURS, 20 MINUTES	
N = 150	N = 50
Time = 1500 minutes	Time = 200 minutes
TOTAL TIME = 28 HOURS, 20 MINUTES	

Obviously, the mix of type of patient visits requires varying amounts of nursing time. This can be used to determine the optimal number of each type of visit the clinic should schedule per day. Since the mix also changes over time, having the data to show the changes can support staffing decisions.

The same techniques could be applied to the exam room and check-out procedure.

Future Development:

We are in the process of replicating this study in two locations: The Veterans Administration Hospital in San Diego, California and The Veterans Administration Hospital in Tulsa, Oklahoma. The Tulsa site is particularly exciting because the clinic is staffed with all RN's. What we expect to see is that basic tasks, such as taking blood pressures, will not differ significantly between clinics with different levels of nursing staff. However, the degrees of teaching and documentation should be different. The tool has been expanded to include telephone interactions in both sites and the Tulsa site has included group teaching in their tool.

In addition to validating our previous data, we are going to try to develop a queuing model to evaluate the complexities of rendering nursing care in the ambulatory setting. In queuing models the goal is to replicate the flow of customers in terms of the speed and frequency with which they are processed. Once the model is accurately designed, the parameters can then be changed and various "what if" conditions can be simulated.

Straightforward simulations have been reported in health care settings. The goal of those simulations were to model the patient flow. Our goal will be to model the nursing care practice as it is affected by patient flow. To date there have not been simulations reported for what is essentially a discontinuous process with different levels of providers. In these studies, we are collecting additional data such as the patient's scheduled appointment time, the patient's arrival time, and what level of nursing staff completed each task. Once we have a model of each of the clinic operations, we will be able to alter variables such as the number of patients scheduled, the appointment schedule process, and the number and type of nursing providers performing various tasks. Obviously, this will be a much more sophisticated tool for planning staffing. For instance, if one wants to build in a nursing assessment time for every patient having a physical exam, then the appointment schedule has to support the activity, and the other clinical tasks must either be completed by another staff member or wait until the nurse is available. This modeling process will provide data on the effects of each practice decision, allowing all the decision-making individuals to discuss, in behaviorally specific terms, what the roles of the nursing staff should be, what level of staff should be used for each task, and what support is necessary in terms of patient scheduling. Then, by collecting data for a few days at various points in time, one would be able to determine whether the staffing plan

ing plan and care standards are being met, and, if not, whether that is due to a change in the patient activity (types of visits, changes in the length of time to complete activities, etc.). Consequently, explicit data are available to negotiate changes in staffing and roles.

These studies have focused on the nursing care activities provided for patients during the clinic day. We have not explored the indirect care activities involved at various times during the day, such as the preparation before patients arrive and closing the clinic. We have also focused our efforts on Internal Medicine clinics, so the times may not be generalizeable to other services such as Pediatrics or very specialized clinics, such as Oncology.

The basic design can easily be applied to any clinic. The data collection process is easily implemented by the nursing staff, does not slow the clinic operations, and is unobtrusive in terms of patient care. Institutions which have in-house operations analysis staff or systems analysts with computer support can work on the statistical analysis. Local universities might provide the staff and facilities to assist. This makes an excellent Master's project if you have affiliating university contacts. One can tie in the results to quality assurance studies, particularly in terms of the time spent in documentation and teaching. Does an increase in the amount of nursing time for individual teaching have an effect on the need for repeat hospitalization? Would an increase in the amount of nursing time for documentation minimize litigation risks? There are certainly many other questions to be explored which have relevance for quality of care as well as dollar value.

Ambulatory settings will probably never have the depth of knowledge about the patients for which they provide care on any given day as inpatient settings have. However, by continuing to study and model ambulatory care practice under a variety of staffing patterns and settings, we will be able to develop easily-applied methods of analysis through which an institution can assess current practices and plan new facilities or programs.

REFERENCES

Barham, V.Z., Schneider, W.R. MATRIX: A unique patient classification system. Journal of Nursing Administration, December, 1980, 10 12, pp 25-32.

Boldy, P. and O'Kane, P. Health operational research - a selected overview. European Journal of Operations Research, May, 1982, 10 1 pp 1-9.

Coleman, J.R., and Kaminsky, C. A financial planning model for evaluating the economic viability and health maintenance organizations. Inquiry, June, 1977, 14 2 pp 176-188.

Coleman, J.R., and Kaminsky, C. Ambulatory Care Systems, Volume V: Financial Design and Administration of Health Maintenance Organizations. Lexington, Massachusetts: Lexington Books, 1977.

Ferretti, W.P. The Sunset Medical Group, P.C. Ambulatory Care. Germantown, Maryland: Aspen Systems Corporation, 1977.

Ford, L. A predictive model of clinic output. Journal of Ambulatory Care Management, November, 1979 2 4 pp 55-65

Genovich-Richards, J. and Tracy, R.L. An assessment process for nursing staff patterns in ambulatory care. Journal of Ambulatory Care Management in Press-Spring, 1984 issue.

Goldsmith, S. Ambulatory Care. Germantown, Maryland: Aspen Systems Corporation, 1977.

Hiller, F.S. and Lieberman, G.J. Introduction to Operations Research. Holden-Day, Inc., San Francisco, 1980.

Hirsch, G., and Miller, S. Evaluating HMO policies with a computer simulation model. Medical Care, August, 1974, 12 8 pp 668-681.

Meyer, D. GRASP: A Patient Information and Workload Management System. Morgantown, North Carolina: GRASP, 1978.

Stafford, E.F., Jr. and Aggarwal, S.C. Managerial analyses and decision making in outpatient health clinics. Journal of the Operational Research Society. October, 1979, 30 10 pp 905-915.

Summer Nurse Extern Program

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Introduction

Collaboration between education and service has long been part of the history of nursing at Michael Reese Hospital and Medical Center. Despite the closing of its School of Nursing in 1981, the Department of Nursing strongly believed it had a role in the education of future nurses. We sought out collaborative relationships with five Schools of Nursing who offer baccalaureate and graduate degrees in nursing. The purpose of this collaboration was to provide a setting in which clinical practice, education, and research resources of service and education would produce benefits for both groups. We wanted the student to benefit and the patient to receive quality care.

Much as been written about the transition from student to graduate nurse and its accompanying crisis called "reality shock" (Kramer and Schmalenberg, 1979). There is also literature to support the fact that new graduates have the highest turnover rate and that the cost to the hospital for replacement has been estimated in the millions (McCloskey, 1974).

It was hoped that our collaboration with education would result in highly skilled practitioners, and would also meet our need to reduce reality shock, and thus reduce orientation costs.

The hospital was not the only party expressing needs. Baccalaureate nursing students have expressed the need to gain a comprehensive work experience which would lead to mastery of manual-technical skills. This would result in increased self-confidence, competency, and self-concept (Kramer, 1981).

In addition, one of our affiliating universities requested feedback on the performance of its students, as well as its graduates who were employed at our hospital. They also expressed interest in collaboration which would include exploration of the preceptor role.

The Nurse Extern Program at Michael Reese Hospital and Medical Center was born out of the expressed needs of the hospital, nursing students and the educational institutions. Initial steps to get the program off the ground included letters of inquiry to institutions offering similar programs. We also consulted with one of our affiliating schools, Loyola University of Chicago, regarding the feasibility of a collaboration of this sort as well as the mechanism for implementation.

The findings of these inquiries resulted in a Nurse Extern Program focusing on quality of patient care. It includes a clinical experience with preceptors and an elective academic course focusing on entry into the work world offered by the university.

Program Goals

The Nurse Extern Program had the following goals:

1. Strengthen service-education collaboration.
2. Contribute to the education of future nurses by:
   a. providing gainful employment;
   b. providing an opportunity to apply knowledge, skills, and judgement in a clinical setting;
   c. using class/seminar sessions to reinforce skills used on the units;
   d. earning academic credit which might satisfy a requirement of schools of nursing.
3. Provide feedback to nursing educators.
4. Initiate student into the work setting.
5. Recruit and retain highly competent new graduates.
6. Shorten new graduate orientation period.

These goals were designed to meet the needs of the hospital, the student, and the educational institution.

Program Components

The program, offered to senior level students from baccalaureate nursing programs, consisted of a self-directed course facilitated by a Loyola University faculty member, a precepted clinical experience, and salary and benefits.

The first component was the academic course, a six week elective nursing course for three credit hours. Two hours per week are assigned for lecture and discussion. Clinical experience in patient care areas under supervision of preceptors accounts for the third hour.

Students are required to investigate and develop self-directed learning activities in relation to their clinical practice. A further focus of the course is the students' assessment of their own resources in clinical care via dialogue with fellow students during discussion periods. There is also discussion on current issues in nursing.

Course content focuses on theories of self-directed learning, motivation, self-esteem, and success. Students are required to present their self-directed learning projects to both their fellow students and members of the clinical units to which they have been assigned.

The second component of the program is the clinical experience. Externs are assigned to medical, surgical, pediatric, or obstetrical/gynecology areas, depending on past clinical experience in school. Each extern is paired with a preceptor who is a member of the unit staff. Attempts are made to schedule preceptors and students on the same shift and weekend rotations. Externs work closely with preceptors during their first few weeks of employment. Independent functioning increases as the extern becomes more confident and skilled. This was planned in response to needs documented by Cronin-Stubbs in her research on new graduate nurses (1977).

The third component of the program is salary and benefits. Externs are paid $6.00 per hour and are engaged in an employment relationship with the hospital. As employees they are classified as "temporary", therefore are not entitled to holiday, sick or vacation benefits. However, are entitled to overtime pay and are covered by liability insurance. Externs may elect to live on the hospital campus, where many amenities (such as shopping and recreation facilities) are available.

Extern Recruitment and Selection

Representatives from the hospital's Nurse Recruitment Section distribute brochures at more than 130 school career days and regional recruitment events. Eighteen to twenty people are selected from among hundreds of inquiries and approximately fifty applicant interviews. Criteria used for the selection of externs includes: senior level students in a baccalaureate nursing program who have good academic standing, suitable references, and clinical experience in area of employment. All candidates who pass the screening criteria are interviewed by the nurse managers of the respective clinical areas. Final decisions are based on academic excellence, as well as demonstrated enthusiasm for learning and making contributions to the clinical setting.

Preceptor Selection and Responsibilities

Preceptors selected to work with nurse externs must have a BSN degree, documented clinical expertise, have an interest in teaching, possess good communication skills, and be selected by their nurse manager.

The responsibilities of preceptors have been specified and include: attendance at the preceptor orientation session conducted by the university faculty, provision of support and guidance, conferences with faculty on a regular basis, clinical evaluation of student, and contribution to overall employee evaluation. The role of the preceptor is considered paramount to the success of the program, therefore special emphasis, support, and recognition is given to this position.

Orientation of Nurse Externs

Nurse externs participate in an extensive orientation, both central and unit-based. Content consists of inservices mandated by JCAH, and general information common to all new employees of the institution. Skills checklists are utilized and a review of the evaluation process is emphasized. Special consideration is given to the uniqueness of both the position and the employees in several sessions. A block of time is set aside to discuss "life in the city" for these newcomers, as well as special time for head nurse - nurse extern social interaction.

Outcomes/Benefits

This program is now in its fifth year of existence. We have found that there have been many benefits to the hospital, the students, and the educational institution. Benefits to the students were numerous. Based on extensive formal and informal evaluations students informed us that:

1. Their senior year was more meaningful based on this experience, they found they had increased knowledge of clinical procedures and increased skills in clinical judgement;

2. Comprehension of ethical issues, as well as death and dying issues was enhanced;

3. Development of beginning skills in negotiating the complex relationships and skills of the work world was attained;

4. Autonomy and self-confidence was gained and skills in assertiveness, and interpersonal interactions were improved.

The hospital benefitted in the following ways:

1. Recruitment of five former nurse externs per year;

2. Provision of a highly skilled pool of workers to meet summer staffing needs;

3. Enhancement of quality of patient care through implementation of student recommendations from self-learning project;

4. Facilitation of preceptor advancement through Clincal Ladder Program;

5. Development of preceptor skills in staff members;

6. Enhancement of relationship with educational institution.

The educational institution reported the following benefits. They:

1. Gained the opportunity to see how well students function with a preceptor;

2. Received feedback regarding basic nursing skills of their students;

3. Enhanced their relationship with service setting;

4. Were provided with opportunity to see the diversity of staff abilities and areas of expertise and to identify multiplicity of resources available.

Evaluations, both informal and formal suggest that this was a successful collaboration. We believe that there were several elements essential to the success of this program.

First, it is necessary to have a faculty which understands the agency and its workings. Second, the staff in the agency must be committed to participation in the education of future nurses. Thirdly, it is necessary to develop written documents prior to implementation of the program. Chief among these are, policies and procedures, job description, preceptor guidelines, course description and evaluation tools. These documents clarify the roles, processes, structure, and interrelationships of program components.

Future Directions

The success of this program suggested many avenues for future collaborative efforts. The possibilities so far identified include:

1. Conduct of an extensive program evaluation.

2. Conduct research projects related to participation/performance variables.

3. Expand faculty participation in other nursing department projects/committees.

4. Explore potential for faculty appointments for qualified preceptors.

5. Continue developing the preceptor role.

Conclusion

We observed that it takes a long time for newly graduated nurses to be fully-contributing professional nurses in an acute care setting. The process is costly for the hospital and stressful for all. The question we asked, based on the above observation, was: Is there a way to shorten the

transition process and make it less stressful? Our solution, based on these facts and conclusions, was to develop the Nurse Extern Program at Michael Reese Hospital and Medical Center.

We found that:

1. The hospital was able to recruit people from the pool of externs and at the same time contribute to the groups' nursing education;

2. The educational institution gained feedback on the effectiveness of its program to produce well-prepared professional nurses; and

3. The students gained an opportunity to sample the employment world before completing their formal education.

Collaboration seems to have worked in meeting the clearly identified needs of three groups while at the same time affording delivery of high quality patient care.

REFERENCES

Cronin-Stubbs, D. Job satisfaction and dissatisfaction among new graduate staff nurses. Journal of Nursing Administration, December, 1977, 44-49.

Kramer, M. Philosophical foundation of baccalaureate nursing education. Nursing Outlook, April, 1981, 29, (4), 224-228.

McCloskey, J. Influence of rewards and incentives on staff nurse turnover rate. Nursing Research, 1974, 23, (3), 239-247.

Schmalenberg, C. and Kramer, M. Coping with Reality Shock, Wakefield, Massachusetts: Nursing Resources, Inc., 1979.

A Service/Education Relationships Model

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The Service/Education Relationships Model is designed to illustrate a pro-active decision-making system that the Nursing Management team at Children's Hospital in Columbus, Ohio uses to determine clinical placement of student nurses. The purpose of this system is to provide for the optimal match between available clinical opportunities and pediatric learning objectives from nine affiliating nursing programs. This paper will review the supporting philosophical perspective of Children's Hospital and the historical development, implementation, and evaluation of the affiliation placement process.

Children's Hospital is a 313-bed tertiary care teaching hospital annually servicing over 180,000 patients from the central and southeastern Ohio region. Children's Hospital recognizes that children are the foundation of an enduring society and that their good health will promote continual improvement in the health and well-being of each successive generation. The mission of Children's Hospital is to provide care to children regardless of their ability to pay for services. Children's Hospital recognizes its position in the health care community as a leader in the delivery of pediatric health care in its service area and believes it has not only the privilege but the responsibility to provide such leadership. Children's Hospital pledges its best efforts and commits its resources to provide the environment, organization, and leadership to promote patient care excellence and education programs for a variety of health care professionals. Approximately 600 full-time equivalent registered nursing positions staff 12 acute in-patient speciality units, four critical care units, 20 ambulatory service units, eight operating rooms, and six ambulatory service programs.

During the academic year 1984-1985 the Nursing Education and Research Section staff collaborated with the Head Nurses and Faculty Representatives to match pediatric clinical opportunities and the learning needs for approximately 900 nursing students. We project at least 45 students will require individually preceptored experiences to meet their clinical objectives. The remaining students are directly supervised by no less than 34 different faculty members from a variety of programs preparing Licensed Practical Nurses, Registered Nurses, and graduates.

Prior to the 1980-1981 academic year, clinical placement decisions were made at an Annual Deans and Directors meeting held at Children's. Faculty prompted their leaders to achieve placement on certain units. The advantages to the Children's Hospital system were clear: schools negotiated clinical placements among themselves and submitted a schedule plan with conflicts already resolved. Limited hospital resources were not spent negotiating student placements. As the demand for inpatient clinical placement became greater and the potential for conflicts increased, serv-

ice personnel were more hesitant to interfere with a negotiation process that had historically produced workable placement arrangements. Unfortunately the disadvantages to both nursing education and nursing care providers were compelling:

1) deans and directors negotiated with limited knowledge about available clinical opportunities;

2) service personnel did not clearly understand the relationship between the clinical opportunities being sought and students' clinical objectives; and

3) Head Nurses played a peripheral role in student learning while holding accountability for the provision of nursing care to patients on their respective units.

The efforts of the nursing education providers (faculty) and the nursing care providers (staff) had become disjointed. The consequences of this situation weighed primarily on the consumers of nursing education (students) and consumers of nursing care (patients). We needed an effective means to promote the application of common professional values to achieve shared goals.

The Service/Education Relationship Model (Figure 1.) represents a cross section of the pro-active decision making process. Providers and consumers of nursing education and nursing care form synergistic relationships to meet their individual and collective needs effectively. This circular movement of the model represents the here and now creative, collaborative exchanges driven by mutual goal identification, represented by the circular direction of the spiral. By studying old patterns we created a new form: a structure that would promote exchanges of people, material, and energy resources for the benefits of the four model roles. One of the objectives of the model was to clarify the importance of strengthening relationships among faculty and patients, staff and students, and faculty and staff. The system immediately increased Head Nurse involvement in the affiliation process and progressively increased staff's awareness of their contribution to students' learning.

The system was initiated when Nursing Education and Research Section members designed the Unit Profile format and collaborated with Head Nurses to present an accurate picture of the available clinical nursing opportunities on each unit. Nursing care providers empowered nursing education providers with the information necessary to request units which would provide the number and quality of clinical experiences best suited to meet students' learning needs. Unit Profiles included information about the following: patient population, nursing care modality, interdisciplinary resources, teaching/learning opportunities and prerequiste knowledge, and experience of faculty and students. Profiles are updated to reflect an accurate picture of the nursing care environment on each unit. This in-

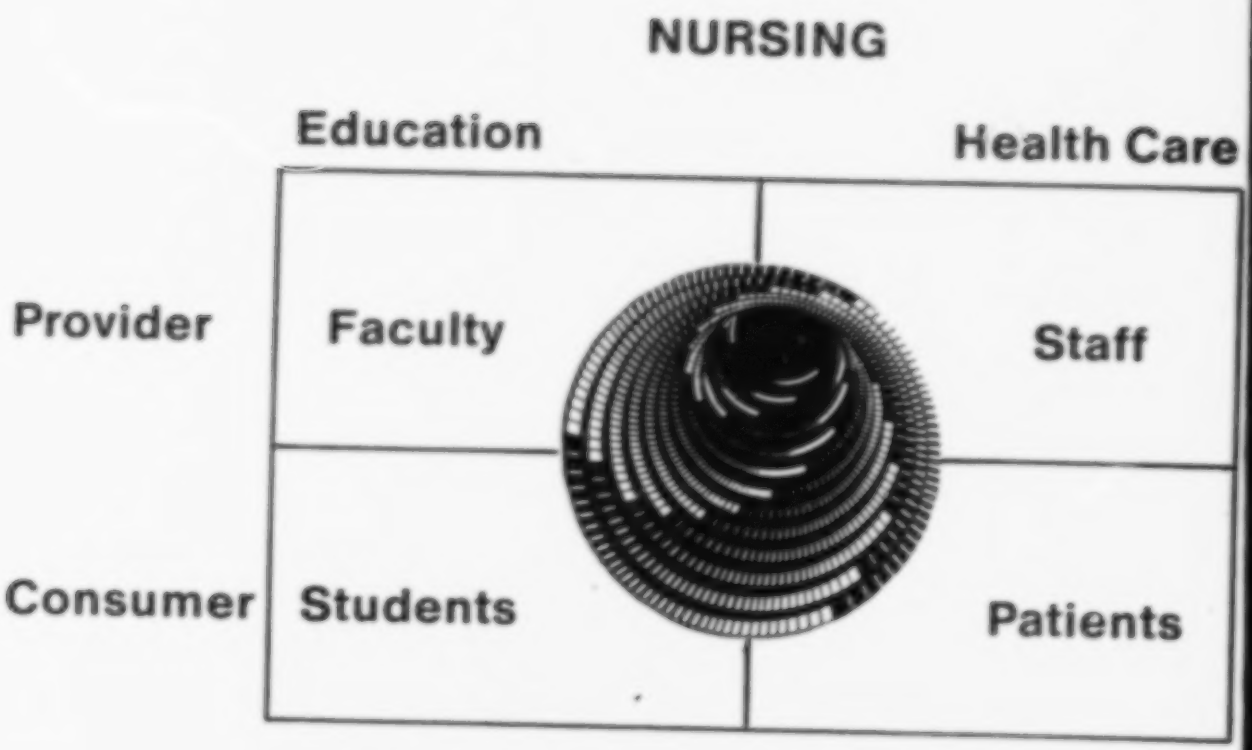
NURSING
Education
Health Care
Provider
Faculty
Staff
Consumer
Students
Patients

Figure 1.

formation was previously unavailable to the majority of nursing education providers.

Nursing educators empowered nursing care providers by supplementing their prioritized unit requests with critical information about course objectives and scheduling parameters. This assisted the Nursing Education and Research staff to formulate a schedule plan that respected both patient care and student learning requirements. Three roles were clarified: nursing care providers' accountability for assuring patient care excellence, nursing education providers' accountability for assuring appropriate clinical learning opportunities for students, and the role of the Nursing Education and Research Section as arbitrator.

The Affiliation Policy formalizes the decision-making process and identifies role accountability for decisions. Examples of decision parameters for direct patient care include: no more than one clinical group will be scheduled per unit per shift, there is a four hour minimum placement requirement, clinical experiences must be scheduled on consecutive days, faculty/student ratio will not exceed one to ten, and the maximum number of students providing direct patient care will not exceed eight.

Nursing Education and Research Section staff review application information and formulate a draft of the master schedule. Schedule conflicts are verbally negotiated with Faculty Representatives and Head Nurses. The final schedule is validated by each Head Nurse before placement commitments are made to the nursing programs.

In addition to direct patient care scheduling, we schedule observational experiences for ambulatory service areas. Due to the increased demand for clinical experiences, the Ambulatory Section developed its own scheduling policy which calls for two priority categories of placement. Students providing direct patient care under the supervision of a faculty member immediately available to the students are scheduled first. Scheduling arrangements are negotiated in a meeting with appropriate Nursing Management and Faculty representatives. Students requiring observational experiences who do not provide direct patient care are scheduled on a space available basis.

Many factors challenge the pro-active decision-making system for clinical placement of student nurses. Some examples include increased patient acuity, decreased census, changes in health care delivery systems, cost of nursing service, and skill competence of staff and faculty. One product of the pro-active decision-making affiliation system is a schedule that meets the needs of many individuals. Another product of the system is the reciprocal, collegial exchanges that enrich the relationships among the providers and consumers of nursing education and nursing care. Some examples of collegial exchange include: staff presentations to student groups, staff/faculty research, audio-visual materials development, clinical/educational consultation and inservice, policy development, joint appointments, and Faculty Representative meetings.

In contrast with its historical beginnings, the format of the 1984 Annual Deans and Directors Meeting provided for communication of individual systems' accomplishments and goals. A reception followed the meeting to enhance collegial networking for synergistic creativity. The future holds many new challenges for our profession. The Service/Education Relationships Model may provide a means to conceptualize the integral relationships among providers and consumers of nursing care and nursing education: care givers will be more sensitive to patient needs, patients will receive care based on current theory, staff will actively participate in the learning environment, and students will have access to collegial faculty/staff role models.

Just as children are the foundation of an enduring society, so too are students the foundation of an enduring profession. Let us embrace our common values and not overlook a single resource as many challenges compete for our collective energies to achieve strength, growth, relatedness, peace, and balance in our nursing profession.

Descriptors for Nursing Care Provided Under DRGs

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Introduction

The American public has demanded a halt to the trend toward further escalation of the cost of health care experienced during the seventies. The legislators have responded with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) which changed the focus of hospital reimbursement from payment for monies spent to a prospectively predetermined payment based on patients' Diagnosis Related Groups (DRGs).

Because of this change in focus, the nurse administrator of today must choose to be "consciously competent", a level of competence evidenced by the administrator's responsiveness to two audiences: the consumer and the nursing staff (Veninga, 1982). In order to be responsive, the administrator needs both qualitative and quantitative data for a baseline. The public has insisted: "lower the rate of cost increase in health care." Nurses have likewise demanded: "maintain the quality of patient care." These values are qualitative in nature. Using them as benchmarks, it becomes clear that some quantitative data are needed. Quantitative data will lessen the uncertainty of the situation in order to plan for changes and particularly to plan for evaluation of those changes. As Kaluzny et al (1982) have stated:

> "One of the most difficult aspects of planning is dealing with uncertainty. Much of the value of quantitative techniques is in their ability to treat uncertainty in an objective, rational, and rigorous manner. This is not to say that quantitative techniques eliminate uncertainty. There is no way to accomplish that. These concepts and techniques are, however, useful for containing the effects of uncertainty on the process of planning or, put another way, allow us to plan even in the face of uncertainty."

In 1982, at the 5th National Conference on Nursing Diagnosis, Toth discussed the trial of DRGs in New Jersey and explored adding nursing diagnosis to the reimbursement formulas (1984). Grimaldi and Micheletti (1982) also reported the New Jersey study, focusing on the costing of nursing care utilizing a method called Relative Intensity Measure (RIMS), which is based on acuity. A debate about the limitations of this model was published in Nursing Management (Caterinicchio, 1983); however, Curtin (1983a) pointed out that without viable alternatives, the limitations may

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well be ignored and this model implemented. In 1983 (b), Curtin wrote an article outlining a method of determining costs of nursing services per DRG. She listed the problems with her method as being "inaccurate assignment of DRG, inaccurate nursing assessment of patient needs, and allowance for the difference, if any, between the care needed and the care received by the patient." Riley and Schaefers (1983) reported their study of costing nursing services at St. Paul-Ramsey Medical Center, St. Paul Minnesota. Their research demonstrated that nursing intensity varied among DRGs and they suggested that nursing staffing can be analyzed and should be planned for on this basis.

Research needs to be continued to develop an acceptable, usable method for costing nursing services and to analyze the actual cost to the hospital for a given patient's care. According to Curtin (1983a) "any item that constitutes as large a share of any hospital's budget as does the nursing department budget simply must be justified."

Purpose

The primary purpose in conducting this study was to develop a useable methodology for correlating nursing diagnosis and nursing personnel hours based on an acuity system related to medical DRGs. The intent of the study included identifying:

1) the nursing diagnosis associated with various DRGs as a descriptor for needed nursing care;

2) the nursing personnel hours based on an acuity system as a descriptor of the time, and therefore dollars, associated with providing this care;

3) the relationship of age and length of stay (LOS) to the range of nursing resources utilized within a DRG category.

In addition to the development of methodology, this study provides an analysis of DRG-specific profile variables of nursing diagnosis, acuity pattern, acuity totals, age, and length of stay (LOS). The study is ongoing, as the data collected to date is insufficient for generalization in identifying needed nursing care that can be calculated as a specific portion of DRG reimbursement. Within the setting for this study, acuity and nursing diagnosis are readily available for analysis to enlarge the knowledge base for decision-making concerning nursing productivity.

Study Description

A descriptive correlational design was developed to describe subjects throughout their acute hospital stay. The independent variables were the patient's age and the DRG assignment. The dependent variables were nursing diagnosis, patient acuity, and LOS. In April, 1984, Mitchell et al, reported a study using almost identical methodology to this study where age, acuity, and DRGs were the variables. Nursing diagnosis was not

reported. Unfortunately, their reported DRGs and those in this study were not the same and do not allow comparisons.

The population of this study consisted of all patients whose hospital bills would be paid by Medicare and who were admitted to four similar general medical/surgical units over a two week period. The hospital setting was Miami Valley Hospital, a 772 bed urban non-profit regional referral center located in the East North Central region for DRG reimbursement. The total number of patients studied was 55, with an age range of 34-94. There were two patients under 65, thirty-seven from age 65 to 79, and sixteen from age 80-94.

Researchers identified Medicare admissions daily by going to each of the four units and reading the unit admission book. The patient's admission face sheet was used to affirm Medicare status, age, and admission diagnosis or potential DRGs. The patient's nursing care plan was checked for nursing diagnoses. All patients' records were checked daily throughout their hospital stay for new nursing diagnoses. LOS was determined when the patient was discharged, expired, or transferred to a DRG-exempt unit such as psychiatric or rehabilitation. After discharge, medical records personnel assigned a DRG for each patient using Health Systems International's DRG grouper.

Patient acuity was printed from the computer on a daily basis and compiled by a volunteer at the end of the patient's hospitalization. The computer system did not calculate total nursing care time per patient for more than an eight-hour time span.

Analysis and Findings

The subjects were grouped by DRG as assigned by medical records division, post discharge. There was a total of 55 patients in 32 different DRG categories. DRG #127, heart failure and shock, had 10 patients; DRG #014, specific cerebrovascular disorders except transient ischemic attack (TIA) had five patients. There were three DRGs with three patients each: #088, chronic obstructive pulmonary disease; #142, syncope-collapse age < 70 without complication co-morbidity (w/o cc); and #294, diabetes age = > 36. The 27 others had just one or two patients in each category.

For each DRG, all nursing diagnoses were listed. These were then reviewed for similarities within the DRG. The expectation was that the same nursing diagnosis would appear on the care plans within the same DRG.

Using the computerized acuity system, direct care hours for RN, LPN, and Trained Attendant were totaled and then averaged. The average cost was determined using mean salary multiplied by the number of hours. The average cost of nursing care per DRG is not reported in this paper, as this would vary from hospital to hospital based on salaries. However, average hours can be translated into dollars by each institution.

Age, LOS range, and mean are also calculated per DRG. The categories reported are the two with the five or more patients per DRG. In addition, the mean of the total required nursing care hours of patients 65-79 were compared with required nursing care hours of patients 80-95.

The methodology used was satisfactory for gathering appropriate data, but the actual number of subjects per DRG was insufficient to reach conclusions and the cost of data collection was high, approximately $17.50 per subject. This included the time and services of two RN's and the Medical Records' DRG coordinator. The volunteer's time was free, therefore not included in the cost. The cost could be reduced by using unit-based clerical workers for part of the data collection and by using a computerized acuity system that keeps retrospective totals of hours of required nursing care. Hinson, Silva, and Clapp (1984) described a computer system that calculates the cost of nursing care per patient for the nursing activity resulting from both the physician's orders and the nursing diagnosis-based orders on the care plan.

The following table gives the findings on age, LOS, total required nursing hours, required RN hours, and average nursing hours per day. Note that the average age in both DRG categories is over 80.

Table 1

DRG Comparison (expressed as mean)

	#127 CHF (n = 10)	#104 CVA (n=5)
Age	81	83
LOS	8	14
Care Hours (RN Only)	49(40)	94(67)
Care Hours/Day	7	7

Table 2 compares the data from this study with the National DRG data in LOS and gives the DRG payment allowed for each of these categories. Geometric mean LOS is calculated a little differently than the arthmetic mean LOS and would give a slightly lower mean. Although nursing care costs are not the only expenses, in this study it is interesting to note that for each hour of nursing care provided, the hospital revenue is one-third more for the congestive heart failure (CHF) patient than it is for a patient with a cerebrovascular accident (CVA).

Table 2

	127 (CHF)	#104 (CVA)
Study's Arithmetic Mean LOS	8	14
DRGs Geometric Mean LOS	7.8	9.9
Total DRG Payment	$4,166	$5,456
Mean Care Hours	49	94
DRG Payment per Care Hour	85.02	58.04

Expressed another way, while each CVA patient brings in 31 percent more revenue to the hospital than each CHF patient, the CVA patient consumes 92 percent more nursing resources. If these figures were verified in a larger sample and the care delivered is judged to be appropriate, then nursing's portion of the revenue should be larger for CVA patients than for CHF patients. Look at Table 3 for an example using numbers proportionately similar to our findings. Note that to provide twice as much care resulted in a 10 percent increase in the portion needed by nursing to deliver the care.

Table 3

Revenue	Care Needed	Nursing Portion
$3,000	50 hrs = $600	20% of Revenue
$4,000	100 hrs = $1,200	30% of Revenue

A comparison of nursing resources consumed by subjects 65-79 years old (young-old) and those resources consumed by subjects 80-95 (old-old) is shown in Table 4. The United Stated predicted rise in the proportion of old-old to young-old increases the importance of this finding. The question remains as to why the over 80 age factor is not part of the formula for these medical conditions.

Table 4

Mean Nursing Hours	Mean Nursing Hours
Young-Old 65-79 Years N = 37 x hours = 47.458	Old-Old 80-95 Years N = 16 x hours = 68.394

The medical DRG designation was not a good predictor of the nursing diagnoses for this patient group. There were two patients out of ten with DRG #127, heart failure and shock, who had nursing diagnoses of impaired physical mobility. In DRG #104, specific cerebrovascular disorders except TIA, there were two patients with nursing diagnoses of potential for injury: potential for trauma, and two patients with nursing diagnoses of impairment of skin integrity. This finding corresponds to that found by Martin and York (1984) that there was little correlation between specific nursing diagnoses and primary medical diagnoses in a sample of 20,000 medical records.

Significance:

A prospective payment system has forced nursing to develop methodologies for collecting baseline data on nursing care costs per DRG. Only when we know what we currently use in nursing resources per DRG can we identify ways to reduce the cost. The percentage of a hospital budget that is allocated for nursing care is reported to be anywhere from 14-21 percent (Walker, 1983), to 30-60 percent (Davis, 1983). Until we know what we currently use in nursing resources per DRG, we will find it very difficult to determine where and how we can reduce the cost for these resources.

Age is currently a factor in the DRG decision tree for some medical conditions, with patients over 70 being allocated a larger amount of money than those under 70 for the same medical diagnosis. It is the findings of these researchers that the young-old, 65-79, require fewer resources than the old-old, 80 and above. This preliminary finding needs additional research.

According to Davis (1983), there are 30 million dollars in the Health Care Finance Administration (HCFA) budget to be used for research and development related to Medicare reimbursement and coverage issues. Nursing needs to tap this available resource to study the economic implications for quality innovations by nurses. Veninga (1982) commented on factors influencing success in change programs and singled out the need "to identify as precisely as possible the nature of the problems the organization is experiencing and to find creative and practical solutions."

So we end this paper with a plea for replication of this study in a variety of settings so nurses can be pro-active in demonstrating the benefit of nursing care in terms of both health status and health care costs. These projects would provide excellent opportunities for nursing education faculty and nursing service administrators to collaborate in directing Nursing's future.

REFERENCES

Curtin, L. A debate: RIM's and the cost of nursing care. (Editorial). Nursing Management, 1983a, 14, (5), 36.

Curtin, L. Determining costs of nursing services per DRG. Nursing Management, 1983b, 14, (4), 16-20.

Caterinicchio, R.P. A debate: RIM's and the cost of nursing care. Nursing Management, 1983, 14, (5), 36-41.

Davis, C.K. The Federal role in changing health care financing. Nursing Economics, 1983, 1, 98-104, 146.

Grimaldi, P.O. and Micheletti, J.A. DRG reimbursement: RIM's and the cost of nursing care. Nursing Management, 1982, 13, (12), 12-22.

Hinson, T., Silva, N. and Clapp. P. An automated kardex and care plan. Nursing Management, 1984, 15, (7), 35-43.

Kaluzny, A.D., Warner, D.M., Warren, D.G. and Zelman, W.N. Management of Health Services. Englewood Cliffs, N.J.: Prentice-Hall, 1982.

Martin, P. and York, K. Relationship among nursing diagnoses and between medical and nursing diagnoses, M. Gordon (Chair), Nursing Diagnoses: A Janus View. The Sixth National Conference on Classification of Nursing Diagnosis at the North American Nursing Diagnoses Association meeting in St. Louis, MO, April, 1984.

Mitchell, M., Miller, J., Welches, L. and Walker, D. Determining cost of direct nursing care by DRGs. Nursing Management, 1984, 15, (4), 29-32.

Riley W. and Schaefers, V. Costing nursing services. Nursing Management, 1983, 14, (12), 40-43.

Toth, R. Reimbursement mechanism based on nursing diagnosis. In M.J. Kim, G.K. McFarland, and A.M. McLane (Eds.), Classification of Nursing Diagnoses: Proceedings of the Fifth National Conference (pp. 90-120). St. Louis: C.V. Mosby, 1984.

Veninga, R.L. The Human Side of Health Administration. Englewood Cliffs, N.J.: Prentice-Hall, 1982.

Walker, D. The cost of nursing care in hospitals. Journal of Nursing Administration, 1983, 13, (3), 13-18.

Model Senior Wellness Centers: Self-Responsibility

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Introduction

The wellness life style is more important today than ever before, however, most wellness programs have concentrated on young and middle-aged adults. Wellness is equally if not even more significant for the older adult, 60 years and older, for the same reasons that wellness is important for the other age groups. There are twenty-two million community-dwelling adults aged 65 years and older, in the United States, and one million older adults living in institutions (Wisocki, 1984). Humanistic concerns mandate that we assist older adults to achieve a level of wellness that will allow for independent living and subjective well-being.

Economic concerns for the increasing health care costs for older adults is a primary force driving the need for change. Health care costs for older adults (11 percent of the population) now accounts for 22 percent of physicians' charges, 28 percent of hospital costs, and 84 percent of the long-term-care costs (Gibson, 1979; Lesnoff-Caravaglia, 1980).

Kaplan (1984) states that health care costs have grown to consume 10 percent of the Gross National Product. These economic concerns will grow as the number of older adults rapidly increases.

One in every twenty-five Americans was 65 years or older in 1900. Today, one in every nine Americans is 65 years or older. Among the older adults, 38 percent are now over the age of 75 years and this proportion will rise to 43 percent by the year 2000 (U.S. Department of Commerce, 1977). The 1980 census data of Minnesota identified 479,746 persons aged 65 years and older. This source states:

> The fastest growing age group in Minnesota is the 75-plus age group. In this state it is estimated that between 1989-2000 the group of persons aged 65-74 will increase by 4 percent, however, the group aged 75-84 years will grow by 22 percent (Minnesota Department of Health, 1981).

Eighty-six percent of the older adults has one or more chronic diseases resulting from life-style behavior and 39.4 percent are limited in major activities (National Center for Health Statistics, 1977). Even though the government pays for two-thirds of their health care, the average older individual paid 11 percent of his/her own medical costs in 1977 (Ford, 1981). These facts are part of the motivating forces that bring seniors to participate in the wellness centers in Duluth and Grand

Rapids. Seventy-five percent of the older adults describe themselves as well (National Center for Health Statistics, 1977) which makes continuous publicity necessary to explain the concept of wellness in regard to the older adult. The need for wellness programs for this population is evident; however, slow but steady progress will be required to elicit interest, understanding of the wellness concept, and the importance of the wellness life style in effecting health care cost containment in health services for this group. Efforts to extend wellness services in the direction of older adults on a national scale have been almost non-existent to date.

Definitions of terms

The term **Older adults** will be used in this paper when reference is made to persons who are sixty-five years and older; and the term **Senior(s)** will be used in reference to the participants of the wellness centers.

The College of St. Scholastica received a three-year grant from the Blandin Foundation, Grand Rapids, Minnesota, for $115,000.00 to develop model senior wellness centers in Grand Rapids and Duluth, Minnesota. Planning and development to prepare for implementation occurred from January 1 until September 1, 1983. Then the operational phase began with half-day services provided at the Bauer Senior Wellness Center at the Itasca County Family Y.M.C.A. on 2nd and 4th Wednesdays on September 14, 1983; the Portman Senior Wellness Center, every Thursday, in East Duluth on September 22, 1983; and the Harrison Senior Wellness Center, 2nd and 4th Fridays, in West Duluth on January 13, 1984.

The concepts of wellness and self-responsibility are addressed in this paper along with the major dimensions of the wellness programs which are: (1) Physical Fitness and Excercise; (2) Nutrition; (3) Stress Awareness and Management; (4) Environmental Sensitivity; (5) Awareness and Management of Drugs; (6) Normal Aging Process; (7) Awareness of Community Resources; (8) Communication Skills; and (9) a summary of wellness activities and participants. The focus of the wellness programs is on self-care and the development of the participants' own network of support for maintaining independent living status and for increasing the quality of life. A description is given of the wellness personnel and of evaluation responses.

Wellness Concept and Self-Responsibility

Most people, including seniors, need some familiarization with the concept of wellness, especially as wellness relates to older adults.

Wellness is a dynamic life style, and is best defined by the individual's acceptance of self-responsibility for her/his own well-being. Wellness is a concept with powerful implications governed by personal values. The wellness life style is unique to each individual and is expressed in the way each individual perceives wellness.

Since self-responsibility is central to the wellness movement, the goal of the wellness programs is to provide seniors with the knowledge of self. They learn how to perform necessary skills, increase their knowledge of health issues, and make deliberate life style choices for their own individual well-being. The seniors must act on their own behalf with information they can acquire, or with information given to them to develop their network of support for independent living. Although the seniors are assisted in accomplishing their goals and objectives by the wellness personnel, they are not told what choices to make. Ardell, (1981), a founder of the "wellness concept" summarizes self-responsibility as, "Ask not what your doctor can do for you. Ask what you can do for yourself". At times this is a difficult concept for many seniors and older adults to understand or implement because some have been conditioned by the medical model to assume a helpless or dependent role where health care is concerned.

According to Ardell the dimensions of wellness include physical fitness, nutritional awareness, stress awareness/management, environmental sensitivity, self-awareness, and self-responsibility. To these five content areas we have added the dimensions of awareness/management of drugs, knowledge of the normal aging process, knowledge and utilization of community resources, and communication skills in expressing self in interacting with family, friends, and health professionals, especially physicians, dentists, and pharmacists.

Wellness is a dynamic continuum, rather than a static state of being such as "being in good health". The seniors use wellness information to aid them in estimating where they are on the premature aging/wellness continuum. This realization helps seniors to be aware of changes needed if they wish to achieve a more beneficial state of wellness.

Seniors at the Grand Rapids wellness center were the first to understand the purpose of the wellness activities. They realized that the wellness personnel were not there to treat or screen them but rather to provide them with information. However, they needed further assistance to understand the concept of individual self-responsibility in regard to wellness in all dimensions. Most are selective in the dimensions for which they take responsibility; and the centers progress at different rates. The seniors at Portman have shown the most progress in the direction of self-responsibility in more of the dimensions, while the seniors at Harrison are just beginning to understand the concept of wellness and self-responsibility.

Physical Fitness and Exercise

Exercise and physical fitness are areas of high interest. This is not surprising because of the extensive publicity and promotion of physical fitness in the media. Initial expectations were that the wellness centers would organize exercise programs as a routine part of center activities. Our approach is to discuss the normal aging process and point out why physical fitness is vital to mobility. The slogan "use it or lose it" is often quoted to the seniors. Qualified resource providers of senior

exercise programs come to the centers to present information on their programs along with demonstrations. Once the seniors know what programs are available in the community it is their responsibility to choose the type of program that is appropriate for them. They can also choose to remain sedentary. Walking as a cardio-vascular conditioning exercise is promoted by the wellness centers. Seniors can do this individually or in social groups, and it is cost free except for the purchase of good walking shoes.

Stretch break exercises, mini-back rubs, range of motion exercises, and self-therapeutic massage are conducted periodically within the center activities. An exercise program was purchased from the Park Nicollet Medical Foundation specifially designed for seniors. The "Over-50 and Fit" exercise program will be implemented during the winter quarter of 1985. Two seniors from each center will be selected and taught how to facilitate the program for other seniors by two nursing students from St. Scholastica.

Nutrition

Nutrition is rated as a high interest in all three centers. Topics on nutrition feature vitamins, sodium, fiber, processing of foods, knowledge of labeling of food products, false claims in advertising of food products, etc. Films, handouts, taste parties, dietitian resource providers and information from current research are examples of types of programs presented to the seniors. Handouts are printed on yellow paper using large type on one side of the page to enhance visibility. Seniors have commented that it helps learning to see, hear, and have handouts to take home to reread in a quiet environment.

Two student dieticians participated in the wellness center program at Portman during the winter and spring quarters. They completed 24-hour dietary assessments and three-day food analyses for the seniors. They found one senior to have a borderline niacin deficiency. The education focus of the dietetic students and wellness personnel was on the basic four food groups, fiber, and vitamin requirements based on Recommended Dietary Allowances (RDA). The seniors in all three centers rely on PREVENTION magazine for nutritional information. Effects of overdoses of vitamins are often discussed to ensure accurate understanding of food nutrition and vitamin supplements. For example, Senior H informed the group that daily ingestion of Vitamin E slows down the aging process and cleans out the arteries. The wellness personnel and the dietetic student did a presentation on vitamin E including the signs and symptoms of toxicity.

Nutritional requirements for bone health is discussed often with a focus on prevention of osteoporosis. Calcium, the calcium-phosphorous ratio, calcium supplements, current research on osteoporosis, and the importance of exercise in promotion of bone health are part of the group lessons every quarter. The normal aging process of bone structure is

addressed so they become aware of what is normal and what is a result of inadequate nutritional intake. After receiving the information, seniors are given an opportunity to determine what changes in their lifestyle are needed to promote bone health. They are made aware of the risks involved in addition to the value of mobility. One senior at Portman was recently diagnosed as having spinal osteoporosis and was willing to share her grief over her loss of mobility. Her self-disclosure of pain, depression, possible loss of independent living status, feelings of hopelessness and inadequacy in communicating with health professionals, etc. stimulated the other seniors to join in the discussion. From this sharing, a cohesive bonding of the seniors took place. Together, they gave support to this older adult and helped her identify alternate strategies in coping with her health problems.

Stress Awareness and Management

Aged persons are not able to handle stress as well as younger persons. The seniors are very aware of this fact. Many techniques are utilized to assist the seniors to reduce stress and develop strategies to deal with stress more efficiently. Meditation and relaxation tapes are played at the centers. The suggestion is made that if they wish to obtain one or more of the different meditation and relaxation tapes for themselves they can communicate the desire to their adult children or grandchildren on their Christmas "wish" list.

Resource service providers come in to demonstrate relaxation techniques, give information on biofeedback, pain control, and on other progams available in the community. One senior nursing student was assigned each quarter to make home visits to one particular senior who needed assistance in identifying stressors in her life. They developed an effective solution to help her control her anxiety during two academic quarters.

Environmental Sensitivity

The inadequacies of public transportation systems in our cities is becoming more evident as the 75-plus population continues to increase. Moreover, public transportation services are decreasing just as older adults' need for these services is increasing. Many older adults find they can no longer drive their own car because of diminished vision, mobility, or ability to react quickly in complex traffic situations, to say nothing of reduced incomes which may not permit the purchase, repair, or necessary insurance coverage for a car.

The Grand Rapids seniors are the least affected by inadequacies of public transportation, because it is a smaller community where driving is easier. These seniors are not affected as much because they have grown up expecting to travel long distances to reach desired destinations. There are many smaller towns located around Grand Rapids and seniors come from these areas to the wellness center. Parking in Grand Rapids and at the "Y" is less complex than in Duluth. Many of the senior participants com-

mute by bus. The Arrowhead Transit Bus System has adapted its schedule of services to meet the needs of the community. Bus schedules are well publicized and easy to obtain.

The seniors at Portman Senior Wellness Center often discuss their problems with transportation. Cost does not seem to be the issue, but rather weather, diminished physical abilities, especially vision, and limited public transportation are some of the concerns expressed by the Portman seniors. Some typical comments are:

"I still drive but my vision is getting worse, I don't know how much longer I will be able to drive."

"I quit driving three years ago. I am 90 years old and I was afraid I might have an accident. It's hard to take the bus."

"I find it difficult to walk in the winter as I am afraid I will slip on the ice. I don't want to break a hip at my age," (86 years old).

"It took me one and one-half hours to take the bus to come here. I had to wait 45 minutes when I transferred to another bus. It was cold and windy," (this male senior came from another part of town and was 88 years old).

The seniors at the Harrison Wellness Center do not generally seem concerned about transportation. Fewer seniors own or drive a car at this center. This group seems proud of their walking endurance. They talk about using the bus system often but do not use it to come to the center because the majority of participants live within walking distance. However, icy and stormy weather does prevent some from coming to the center.

Transportation concerns are discussed within the wellness activities because of the importance of being able to commute to the service providers in the community. Transportation is also a factor when attempting to encourage other seniors outside of the immediate neighborhood to become participants of the wellness centers. One 86 year old woman wanted to come to the wellness activities, but she was not able to walk the six blocks. Although the nurses offered to pick her up and take her home each time, she was reluctant to accept the offer, and only agreed when she could pay $1.00 for each trip. Even so, she said she felt guilty for being a bother. Several months later she solved her transportation problem by inviting a friend who drove to come to the wellness center. Her senior friend is now a regular participant.

Other environmental concerns discussed at the centers are safety factors in the home for prevention of accidents, and weather problems of extreme heat and cold, so that the seniors can assume better control of their environment.

Awareness and Management of Drugs

Medications are of high interest at all three centers. Understanding of drug management is vital to the seniors' well-being. The proportion of prescription drugs obtained for older adults is rising. In 1965, one-fifth of the prescriptions written were for older adults compared to one-fourth today (Wynne and Heller, 1973). The use of over-the-counter (OTC) medication has similarly increased. The majority of seniors at the wellness centers do not consider OTC medications to be drugs.

Although interest is high, their knowledge about medication and OTC drugs is very inadequate. They lack awareness of the potential dangers of drug consumption. In one study it was shown that their greatest lack of knowledge was of side effects of drugs. Three-fourths of the patients in the study did not know the symptoms that might indicate adverse drug reactions (Galton, 1976). The same areas of knowledge were lacking in the seniors at these centers. They tend to rely on drugs to take care of all their physical problems. The combined lack of knowledge of side effects and ignorance of signs and symptoms of drug toxicity is an increasing concern as the aging process continues and the medications are used. The signs and symptoms of these drug problems tend to mimic and exacerbate the myths of aging, such as somnolence, forgetfulnes, and incoordination of movement.

The media especially foster many misconceptions about drugs and their effects. For example, television promotes the idea that aches and pains are instantly and completely dispelled by the product advertised. A pharmacist gave a presentation on pain-relieving medication at the Portman Wellness Center and addressed this controversial advertising.

These seniors rarely communicate with their pharmacist or physician to obtain drug information or to review their medication-taking behavior. The following comments support this assumption:

"He (the physician) is so busy I don't want to bother him with questions about my medications."

"Now that I have seen and heard him (the pharmacist) maybe I'll go talk to him about my drugs."

"I had a rash on my neck so I stopped taking my blood pressure pill (wife stopped taking hers at same time). No I didn't tell my doctor. I am watching my blood pressure and when it gets high enough I'll start taking it again."

"I found out I am a diabetic. I am so scared and was put on a pill for this. I stopped taking the pill for my diabetes because my husband said we couldn't afford it. No I didn't tell my doctor," (referral made to Public Health Nursing Department and to physician).

"I don't take my blood pressure pill when I take trips--the bathroom problems you know. No I never tell my doctor. I start taking them again when I get home."

"I didn't know my drugs had any side effects."

"I took my wife all over the state to different doctors because she was so tired all the time and complained of a very dry mouth. I landed at the Mayo Clinic before we found out it was side effects from a medication she was on."

"If I have heartburn or stomach pain I just take a swig of my antacid."

Multiple methods are utilized in wellness centers to assist seniors in acquiring adequate drug knowledge to make intelligent decisions about their medication. Group lessons were given on Lanoxin™ and diuretics but responses from seniors at Grand Rapids and Portman were neutral. An assessment was done on the kinds of drugs taken by these two groups. To our surprise, although they were taking many kinds of medications, duplication of drugs was minimal. Group teaching at all three centers now consists of general drug information such as: drug-drug interactions; drug-food interactions, toxicity of drugs in relation to the normal aging process; films on the best use of drugs; pamphlets and handouts; pharmacists as speakers; and general review of the purpose of a drug history, and how to complete a drug history record. Specific drugs and their side effects are dealt with in the one-to-one teaching sessions. All the information obtained about drugs is shared among the seniors themselves in this type of setting. As a result of the one-to-one teaching and the group education on drugs, the drug behavior modifications were mostly positive. Success of the program is measured by seniors' ability to assume self-responsibility for making whatever changes are needed.

The Grand Rapids seniors are the most progressive group in seeking one-to-one teaching. Sequential numbers are given to the seniors to organize the continual flow of participants into the assessment room. The seniors at Portman and Harrison are more reluctant to participate as they prefer the group presentations. The individual appointments are used to complete drug assessments.

A drug handbook is available as a reference at all three centers. The handbook was chosen by a subcommittee of six seniors in Duluth. From among eight different types of drug information books, they chose the Nursing Drug Handbook, because it was clear and well-organized. Copies of this reference were then purchased for each center.

Progress in acquiring drug knowledge and positive behavioral modification have now been demonstrated in all three centers. The progress is slow but continuous. A Drug Education Workshop has been developed for small groups of eight seniors. The workshop is held weekly for one and

one-half hours at each wellness center on different days over a five week period. Two senior nursing students participate in the workshops as co-leaders. The rationale for the small group drug education workshops is that drug education with large groups has been shown to be less effective except for teaching the basic principles. Individual needs can best be met in smaller groups with reinforcement through one-to-one teaching.

The Normal Aging Process

The presentation of the normal aging process can be a touchy subject because of the negative connotation aging is given in our society. In the beginning the wellness personnel presented one topic at a time including aspects of the aging process, nutrition, and a related drug used in treatment. The wellness personnel sensed and received comments from the seniors that too much information was being presented at one time. Now the normal aging process is integrated with all topics in some way.

Current literature is being reviewed constantly with regard to the normal aging process. In one case, out-of-date information stated that the majority of older adults could expect to lose two-thirds of their ability to taste by the age of seventy. In our senior population only one of the participants, a 74-year old, stated that she had a severe loss of the sensation of taste, and she was taking several drugs. In a study of older adults by Baum it was found that only 10 percent of healthy subjects reported diminished taste sensation, but 30 percent of those taking medications reported taste changes (U.S. Department of Health and Human Services, 1981). The positive news on the normal aging process was shared immediately with the seniors. A sense of humor in the discussion of the normal aging process is appreciated by every one.

By the end of the Fall Quarter 1983, the seniors stated on their evaluation forms that they wanted more information on the aging process.

Awareness of Community Resources

The community resource service providers contribute a wealth of information in all three centers. The seniors were amazed and enthusiastic about receiving this information. A continuous comment was, "I didn't know this service was available." or "I am so glad to get this information, I have a friend who needs this service." The resource persons have been very cooperative and so far have volunteered their time. There is money available to pay an honorarium fee of $50.00 to one resource person in each community per quarter. These funds are utilized when the same resource person comes to the centers three times. Two resource persons have received the honorarium at this time. Both communities are very fortunate to have these resources available; and because seniors are now informed about them, they should be utilized more.

Some of the seniors base their decisions to come to the wellness centers on who the speakers are. They are reminded that the resource people are not there to entertain them, but that they need to take advan-

tage of the information for their own future use; or to refer the information to family and/or friends who provide assistance or care for them.

A panel consisting of representatives from Legal Aid, HMO Minnesota, and Senior Coalition presented insurance information for seniors including Medicare, Medicaid, guidelines in selecting supplemental insurance, and how to communicate effectively with hospital personnel, physicians, etc. The message conveyed was that the seniors must accept the responsibility to question decisions made by others about their health care such as being rushed out of the hospital after treatment. They are counseled not to sign any statements agreeing to pay additional fees. Responses to this discussion were gratifying.

Health Professionals and Communication Skills

Administrative leaders and resource service providers in each community were contacted to introduce the philosophy, goals, and intended activities of the senior wellness centers. Names of physicians to contact for the advisory boards in Duluth and Grand Rapids were requested and received. It was desirable to have physicians on the board who were interested in the concept of wellness and who enjoyed working with older adults.

While interviewing the Director of Social Services in Itasca County I was informed that physicians often view the word clinic as a red flag (originally the centers were named wellness clinics). Noting that the dictionary defined the word clinic as a place for screening or treatment, the word 'clinic' was changed to 'center' to avoid any possible misunderstanding of our purpose in developing the senior wellness centers. A form letter was then drafted describing the philosophy, goals, purposes, and intended activities of the senior wellness centers. The wish was expressed that we could work together in behalf of the senior population. This letter was sent to every physician in Duluth and Grand Rapids.

Two weeks after the letter had been sent, the physicians who had been referred by other community leaders were telephoned and an appointment was requested so that the concept of the wellness program for seniors could be shared and the position on the advisory board from their discipline could be filled. It became apparent that no personal interviews would be possible with physicians or dentists. They were the only groups with whom personal contact was denied. A personal interview was believed to be more effective in gaining cooperation and better understanding of the concept of the wellness centers. Despite the initial resistance, the advisory board positions for physicians were filled in each community. The suggestion was made that each physician choose an alternate physician in the event their busy schedule would prohibit regular attendance at the advisory board meetings. The physician in Grand Rapids did choose an alternate, and one or the other attends board meetings regularly. The physician in Duluth did not choose an alternate and his attendance was sporadic. He resigned after one year; however, he did recommend several

physicians he thought would be interested in taking his place as a member of the wellness advisory board.

In June 1983 I spoke to the medical staff at Itasca Memorial Hospital in Grand Rapids. I introduced the goals and concept of the wellness centers and was told by the physician on the advisory board for this community that the physicians had expressed concern about duplication of services already provided by the clinics and by other community resources. The result of this meeting was positive in that they stated they wished to cooperate with the proposed wellness centers. They sent a two-page letter stating objectives and areas of education that they hoped the wellness center would address. They also expressed interest in consulting with the wellness coordinator every six months. This kind of cooperation was not obtained from the physicians in Duluth. The fact that Duluth was so much larger than Grand Rapids made it difficult to converse with physicians in a group setting. Although it was not essential that physicians be involved in this program; nevertheless, their involvement leads to improved communication with the seniors and the wellness personnel. Valuable information can be shared between the wellness efforts and the physicians, and indications are that this would lead to achievement of desired health goals sooner.

Communication between the seniors and the physicians is of great concern. The seniors were raised in an era which endorsed treating the physician with great respect. It was not considered appropriate to question the physician about drugs, tests, or treatments that he prescribed. The seniors were then and still are dependent on this medical model which results in "learned helplessness."

One goal of the wellness centers is to promote interdependence with the health professionals. The seniors are encouraged to exercise self-responsibility in order to have some personal control in the decision-making process of their health care. The seniors are made aware of their responsibility in the communication process with their physician whenever they express complaints about not being able to talk to physicians. Complaints most often expressed are:

"My doctor is so busy, I don't want to bother him."

"My doctor doesn't like old people. He rushes me and doesn't listen to me."

"My doctor seems so rushed he is too busy to hear my problems."

"My doctor doesn't give me time to ask questions. I paid a lot of money to see him and I left feeling I might as well have stayed home. I feel so intimidated by my doctor that I sometimes forget what I wanted to ask him."

Through these discussions the seniors are learning to improve communication with their physician(s). They are given assistance in organizing the necessary questions to obtain needed information on 3" by 5" index cards and put these in their purse or pocket as reference when they are in the physician's office. They have been informed that it is their responsibility to ask for what they need. When they are more appropriately assertive in taking care of their own needs the physicians will be more responsive. The key for them to understand is that they are paying for the service and it is up to them to receive what they pay for. If they continue having difficulty in obtaining the information and care they need, they are reminded that they have the option to choose another physician.

Self-responsibility is promoted by suggesting that they ask for explanations of prescribed tests, treatments, drugs, etc. so they can begin to understand what is happening to their bodies as a result of the medical care they receive. Some of the seniors in Grand Rapids and at Portman are beginning to assume self-responsibility to gain this type of information. The ones that have become more assertive are reporting more satisfaction with their care. A decrease in complaints concerning their physician's care has been noted when seniors assume some personal control. Perhaps most satisfying is the obvious increased self-esteem shown by these seniors. It became apparent in all the wellness centers that the seniors require assistance to start taking risks on their own behalf.

The seniors at Portman are also demonstrating improved communication with their physicians. Senior H went to see his physician upon request and when he had seen him the physician said, "I don't know why you are here. There is nothing wrong with you." Three weeks later senior H received a bill from the physician for $36.00. Senior H was able to get the charge cancelled because he had received no services. Senior D was recently in Minneapolis for extensive tests and has written for copies of her records and an itemized list of costs for her care. Senior E recently changed physicians because she was not satisfied with her former physician's response and services. She said, "I thought I had to stay with the doctor I have always had because I had gone to him for a long time. I am so happy I changed because I can talk to my new doctor and he listens."

In Grand Rapids, too, the seniors are beginning to communicate more effectively with their physicians. Senior I had a "mini" physical and asked for an itemized account of the tests and care received. She also asked for the results of the test and wrote them down. She was smiling as she informed the wellness staff of her actions and felt more in control of her care. Senior B is writing her questions down before she sees her doctor. The seniors at Harrison have not yet demonstrated the types of changes mentioned above. Delay in assuming self-responsibility for their health care is most likely related to not having the wellness information as soon as the other two centers.

Wellness Personnel

The combined efforts of nursing, gerontological, and dietetic students from the College of St. Scholastica; senior volunteers from the Retired Senior Volunteer Program (RSVP); a senior from the Senior Aides Program, the wellness coordinator; and community resource persons make up wellness center personnel. A short description of the types of activities and the hours of effort for each person is discussed for each discipline.

There are two senior volunteers, Senior E and Senior L, that donate three hours on 2nd and 4th Wednesdays at the Grand Rapids Wellness Center. Senior E's activities include registration, passing out brochures when needed, identfying new participants, helping new seniors fill out the personal information questionaire, and distributing number cards to seniors for assessment and/or one-to-one teaching sessions. Senior L does minimal record-keeping such as making out new charts, filing, preparing the evaluation forms for the session (filling in the topic data, type of presenter, and the date), recording suggestions made by seniors, etc. The two senior volunteers live in Grand Rapids and know the people of the community which is most helpful to the wellness coordinator especially for identifying new participants. Their dependable services contribute to the efficiency as well as the friendly atmosphere of the wellness center.

Senior T works at the wellness centers in Duluth performing registration and minimal record-keeping tasks, she also does minimal clerical work in the office.

Seventeen nursing students have completed their public health nursing experience with well seniors at the wellness centers within the communities of Grand Rapids and Duluth. Five gerontology students have completed their internships at these wellness sites. Four dietetic students were involved with nutritional activities at the Portman Wellness Center.

Nursing students are involved with the Grand Rapids Wellness Center on the 2nd and 4th Wednesdays doing group teaching, assessments, one-to-one interviews, etc. On the 1st and 3rd Wednesdays they work with the Itasca Public Health Nursing Department. They make rural and in-town home visits accompanied by public health nurses as supervisors, assist at outreach clinics, attend meetings, and participate in the Hospice program. The students benefit from these experiences both professionally and personally.

A senior nursing student wrote, "My experience at both institutions was of the highest quality. I feel that the Wellness Center was a vital asset to my personal and professional growth. I encountered many seniors who are enthusiastic, energetic, and highly motivated. Any traces of stereotypes regarding older adults that I had before were definitely extinguished". The seniors of this center often express delight that the students are part of the wellness personnel and miss them during quarter breaks.

The Duluth nursing students are involved with the same type of activities at both Portman and Harrison. Their community experience involves

interviewing three resource service providers and scheduling them to speak at the centers. During the winter and spring quarters one nursing student was assigned each quarter to make home visits to Senior E. This 86-year-old woman was having frequent periods of high anxiety, so the students worked with her to identify areas for potential change which would reduce stress.

An R.N.-baccalaureate student was involved with a blood pressure teaching project and he taught one group session at the Harrison Wellness Center. The opportunity for the students and seniors to work together was beneficial to both groups. A senior nursing student wrote, "I was given the opportunity to teach on a variety of health-related topics and found the clients both receptive to new ideas and curious to know more. The senior population of our community has been a vast untapped resource for spreading the wellness message."

During the spring quarter the gerontology students were involved in community outreach for all three centers. In Grand Rapids, one student interviewed and scheduled community resource providers to speak at the wellness center for a 3-month period. She also facilitated a memory-improvement class on the 1st and 3rd Wednesdays and assisted with group teaching on the 2nd and 4th Wednesdays. In Duluth the focus of two gerontology students was to contact the clergy in east and west Duluth to discuss wellness center concepts. Clergy were encouraged to communicate with members of their parish to let them know that such a program was available. A second purpose for contacting the clergy was to identify homebound seniors who might benefit from wellness activities.

The dietetic students worked with the seniors at Portman Wellness Center providing nutritional activities such as group teaching, 24-hour dietary assessements, and three-day food intake analyses. The 24-hour assessments and the food analyses took approximately 45 minutes each for every senior. Some seniors preferred not to miss the general wellness presentations, and so the dietetic students cooperated by scheduling their appointments before or after the general presentations. Seniors' responses to dietary interviews supported the belief at the Portman center they were eating a nutritionally balanced diet.

Summary and Discussion

One hundred and forty-eight seniors have participated in the 67 sessions at the three wellness centers which included delivery of approximately 52 presentations on different health topics. Seventy-two seniors have participated at the Grand Rapids Senior Wellness Center with average attendance of 30 to 35 seniors. The age span of the participants in Grand Rapids is from 62 to 95 years. Forty-six seniors have participated at the Portman Senior Wellness Center with average attendance of 9 to 15 seniors. The age span at Portman is from 64 to 90 years. Thirty seniors have participated at the Harrison Senior Wellness Center with average attendace of 17 to 22 seniors. The age span at Harrison is from 58 to 90 years.

Expanded wellness activities for the Duluth Center consist of making home visits to homebound seniors whose names are supplied by the clergy. The homebound seniors will be assessed and informed of available community resources to assist them and their families.

The wellness centers are successfully assisting the seniors to assume self-responsibility in their individual health care, maintain their independent living status, and increase the quality of their lives. The progress we have seen for our seniors is slow but constant. Perhaps the seniors' comments are the best evidence of the enthusiasm displayed in the centers for this wellness movement.

"I am so glad that this type of program is here. We should have had something like this a long time ago."

"I feel like I have some support and a place to go where I can ask questions and get some answers."

"I had feelings of hopelessness before I started coming to the wellness center."

"I feel such a loss when I have to miss one of these meetings."

"Besides learning so much I have fun while I am here."
"Do keep coming. I learn so much."

"I wish we would have had teaching on how to effectively communicate when we were young."

It has been an exciting year working with the seniors and the wellness personnel in promotion of the wellness life style for the senior population in both communities. We have learned from each other. The seniors demonstrate active participation by asking questions, sharing information, and teaching us, as well as being taught.

REFERENCES

Anderson, Sir W.F. Is health education for the middle-aged and elderly? FCH/Aging and Health Promotion, 1981, 1-10.

Ardell, D. The nature and implication of high level wellness, or why "normal health", is a rather sorry state of existence. Health Values, 1979, 3, (1), 19.

Ardell, D.B. & Tager, M.J. Planning for Wellness. Dubuque: Kendall/Hunt, 1981.

Brody, S.J. Evolving health delivery systems and older people. American Journal of Public Health, 64, (3), 245-248.

Catford, J.C. Positive health indicators-towards a new information base for health promotion. Community Medicine, 1983, 5, (2), 125-132.

Campbell, R. & Chenoweth, B. Health education as a basis for social support. Gerontologist, 1981, 21, (6), 619-627.

Dery, G.K. An approach to health assessment of women. Nursing Clinics of North America, 1982, 17, (1), 127-136.

Dinsmore, P.A. A health education program for elderly residents in the community. Nursing Clinics of North America, 1979, 14, (4), 585-593.

Ford, A.B. Is health promotion affordable for the elderly? FCH/Aging and Health Promotion, 1981, 29-38.

Hentges, K. Health activation education for self-care. Health Education, 1978, 2, 7-8.

Hentges, K. Education for Successful Aging. Life Long Learning: The Adult Years, April, 1980, 20-23.

Galton, L. Drugs and the elderly. Nursing '76, 1976, 6, (8), 39-43.

Gibson, R.M. & Fisher, C.R. Age differences in health care spending, fiscal year 1977. Social Security Bulletin, January, 1979, 42, 3-16.

Lesnoff-Caravaglina, G. Health Care of the Elderly. New York: Human Science, 1980.

Minnesota Center for Health Statistics. Minneapolis: 1982.

Minnesota Department of Health. Minneapolis: Office of Community Development. October, 1981.

Rosen, H.J. Modern health care delivery for the aged: a program in total health maintenance. Journal of American Geriatrics Society, 1972, 20, (10), 505-509.

Rubin, B. Senior centers and health care. Aging, May-June, 1978, No.s 283-284, 21-25.

State Planning Agency. Faces of the Future. St. Paul: Office of the State Demographics, 1977.

U.S. Department of Commerce. Bureau of Census: Population Estimates and Projections. Current Population Reports. No. 704, 1977, 25.

U.S. Department of Health, Education, and Welfare. Special Report on Aging: 1981. National Institute of Health.

Wisocki, P.A. Behavioral approaches to gerontology. Progress in Behavior Modification, 1984, 16, 121-157.

World Health Organization-UNICEF. Primary health care. Report of the 1978 Alma-Ata Conference, 1978.

Wynne, R.D. & Heller, F. Drug over-use among the elderly, a growing problem. Perspective on Aging, 1973, 11, 15-18.

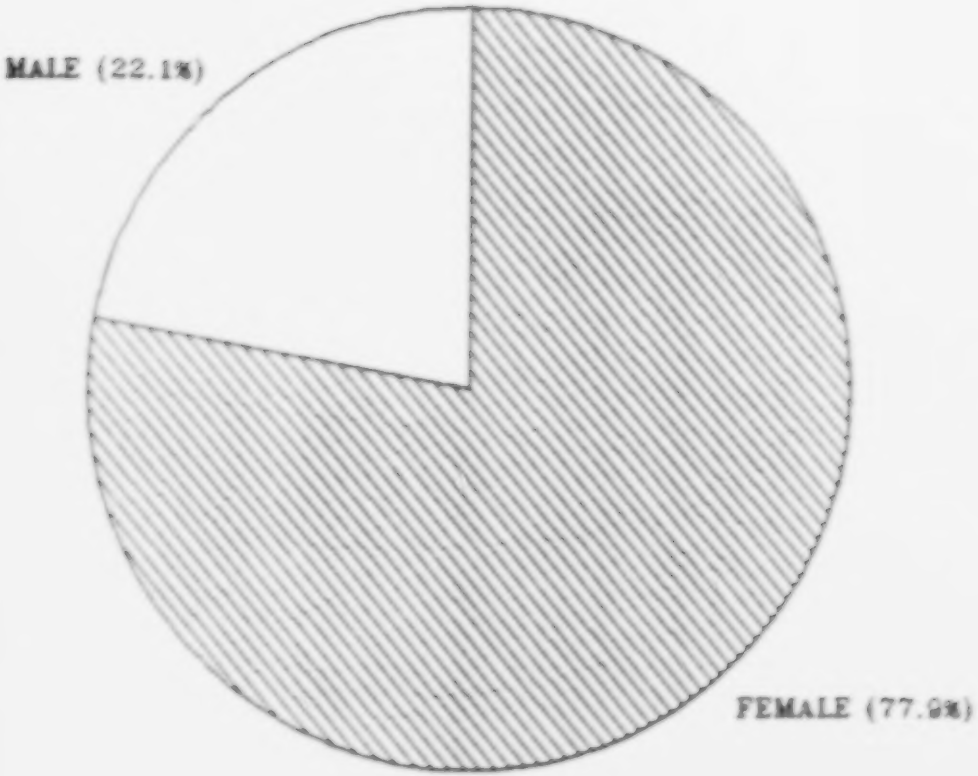
APPENDIX

AGE DEMOGRAPHICS

	HARRISON	PORTMAN	GR. RAPIDS
FEMALE	19	35	48
AGE RANGE	58-79	60-90	57-92
AVERAGE AGE	67.5	70.8	68.7
MALE	8	9	12
AGE RANGE	58-90	70-86	65-92
AVERAGE AGE	73.4	76.5	75.7

Appendix A

WELLNESS CENTERS ATTENDANCE
BROKEN DOWN BY SEX



SENIOR
TRANSPORTATION
NEEDS

	HARRISON	PORTMAN	GR. RAPIDS
OWN A CAR			
YES	17	35	46
NO	9	8	23
DRIVE A CAR			
YES	12	32	45
NO	14	12	14
SOMEONE TO HELP WITH TRANSPORTATION			
YES	15	20	26
NO	4	1	7
NO ANS	6	23	22
NEAR BUS LINE			
YES	24	37	28
NO	3	7	23
DIFFICULT TO TAKE BUS			
YES	4	8	10
NO	17	35	33

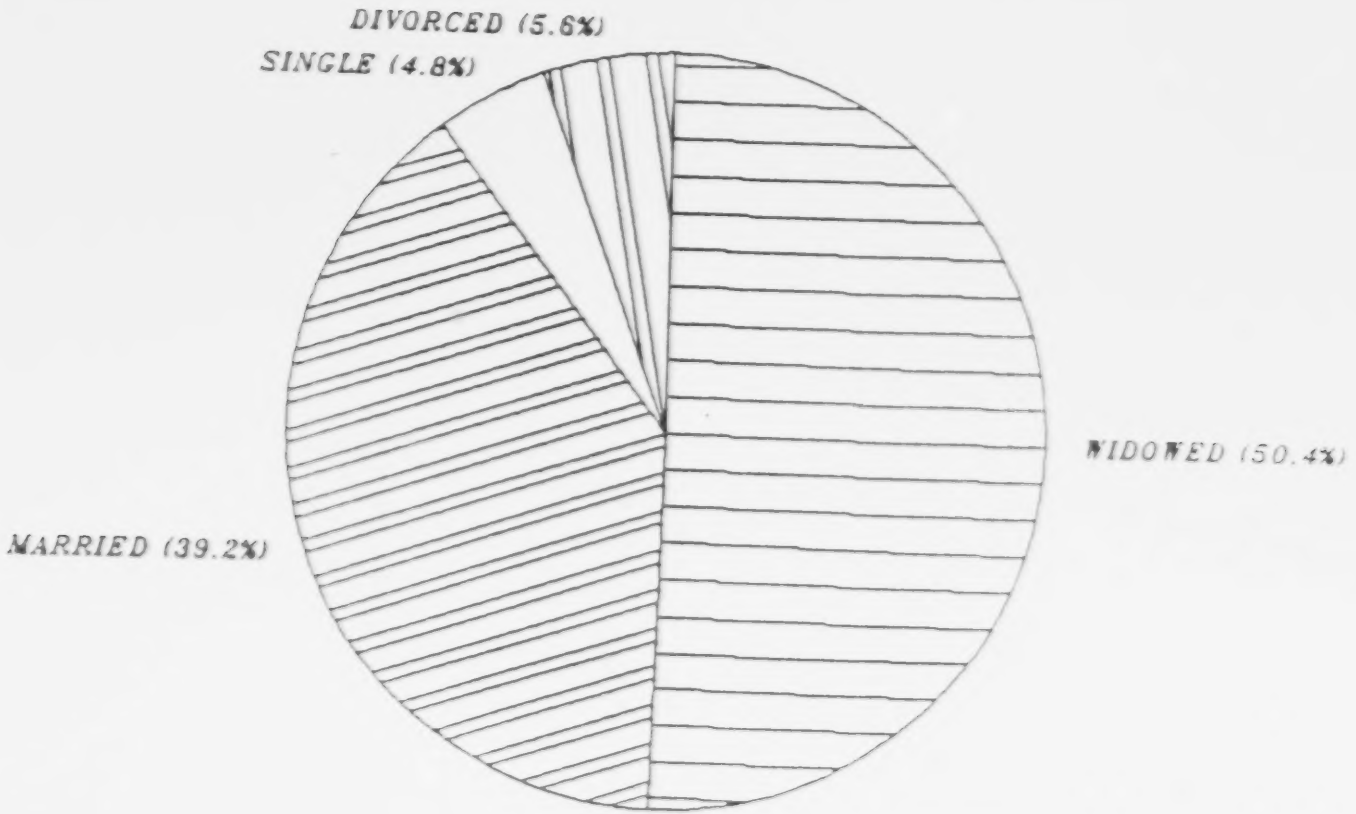
Appendix C

SENIOR DEMOGRAPHICS

	HARRISON	PORTMAN	GR.RAPIDS
WIDOW	13	19	26
WIDOWER	1	2	2
MARRIED	11	16	22
SINGLE	1	4	1
DIVORCED	1	2	5
OWN HOUSE	22	42	39
APARTMENT	5	2	7
SENIOR HIGH RISE APATRMENT	0	0	12
LIVE ALONE			
YES	14	24	34
NO	12	20	23

Appendix D

MARITAL STATUS



Appendix E
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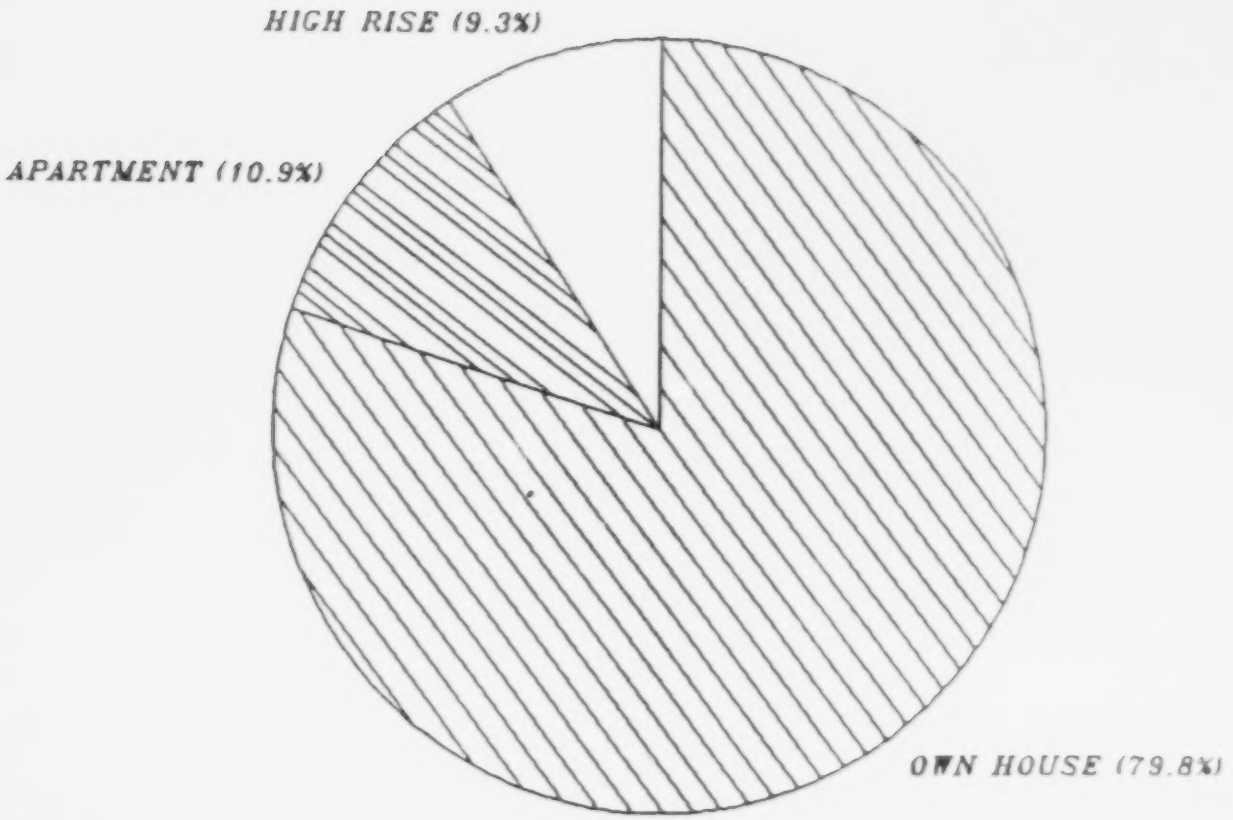
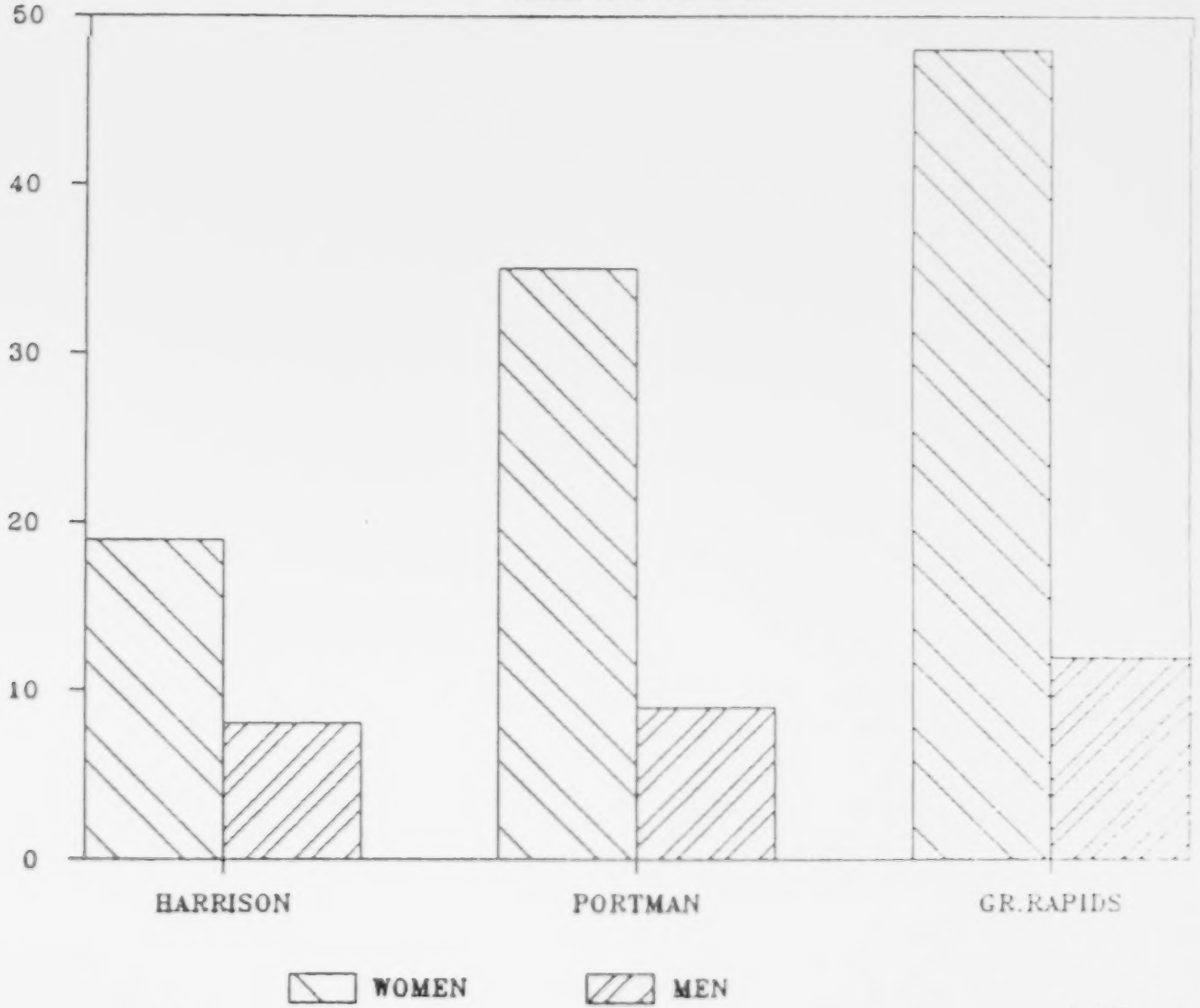
SENIOR
HOUSING



Appendix G

WELLNESS CENTERS ATTENDANCE

MALE AND FEMALE



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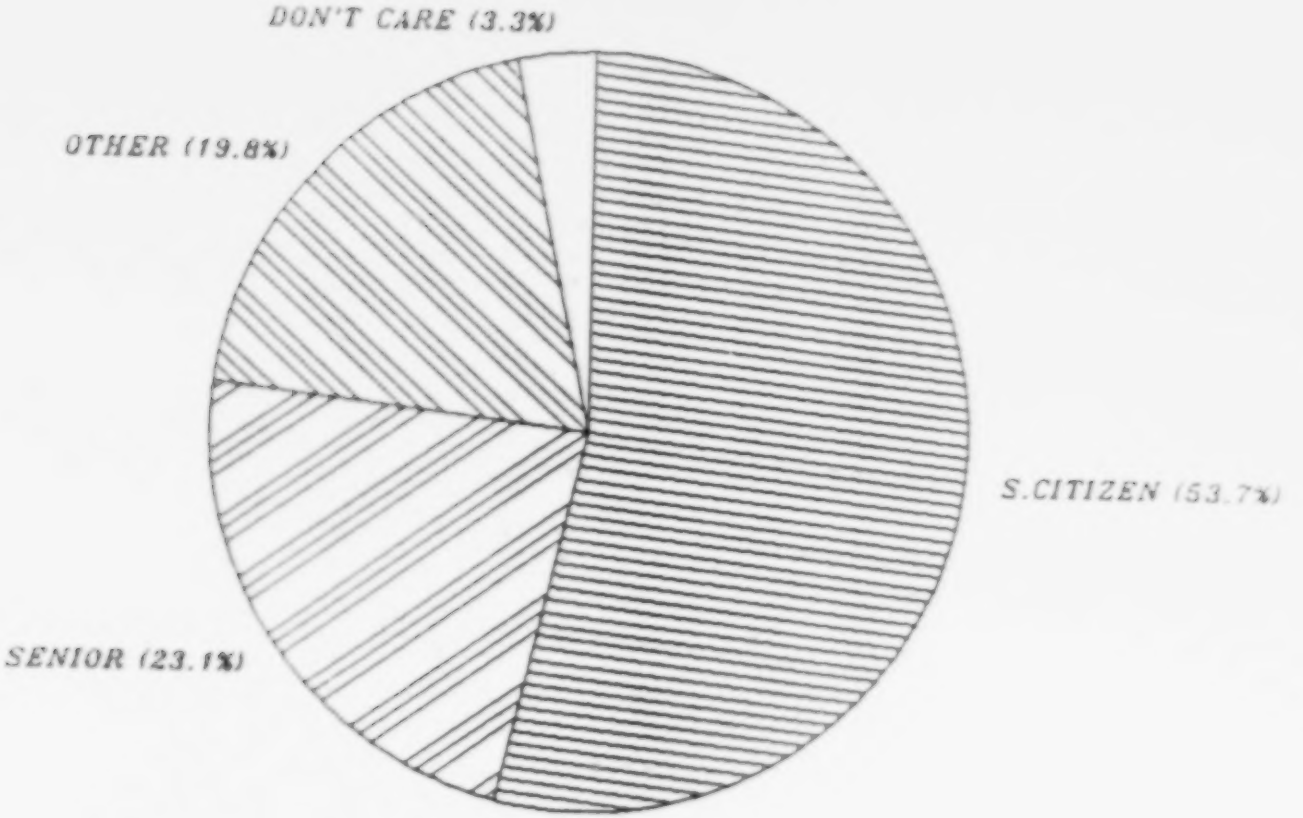
SENIOR
SELF
CLASSIFICATION

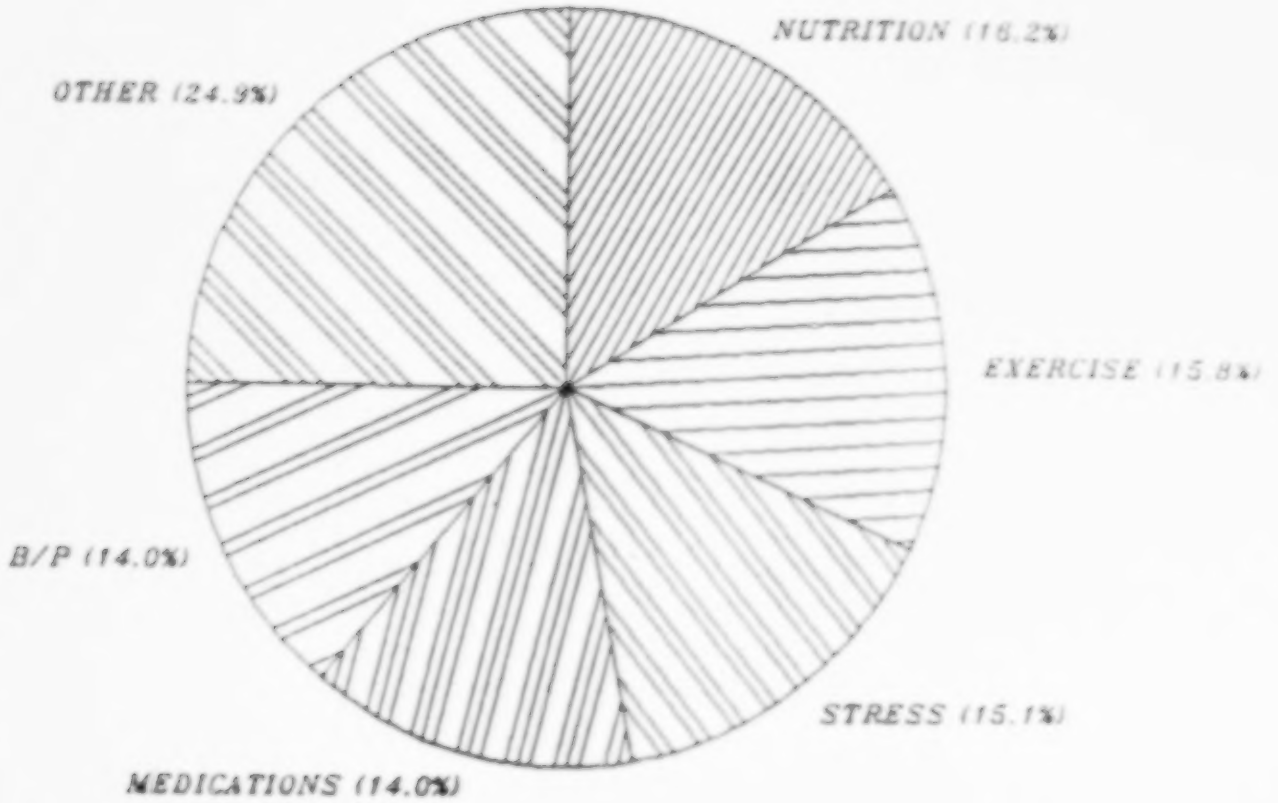
	HARRISON	PORTMAN	GR.RAPIDS
SENIOR CITIZENS	12	23	30
SENIORS	8	13	7
ELDERLY	0	0	0
OTHER	5	8	11
DON'T CARE	0	0	4

SENIOR

SELF CLASSIFICATION



HEALTH EDUCATION
PREFERENCES



Appendix J
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ERIC Clearinghouse for Junior Colleges
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